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ABSTRACT

Five bulletins of the National Center for Clinical Infant Programs include articles with the following titles and authors: "Infant Day Care: A Cause for Concern?" (Jay Belsky); "Model versus Modal Child Care for Children from Low-Income Families (Donna Wittmer); "Therapeutic Childcare at Merrywood School" (Maxine Siegel); "Individual Differences in Infants" (Lois Murphy et al.); "The 'Gourmet Baby' and the 'Little Wildflower'" (Edward Zigler and Mary Lang); "Infant-Parent Psychotherapy with an Autistic Toddler" (Barbara Kalmanson and Judith Pekarsky); "Parent Training with Young Autistic Children: A Report on the LEAP Model" (Philip Strain); "Point of View: Commenting on P.L. 99-457" (Linda Gilkerson et al.); "Selective Review of Infant Day Care Research: A Cause for Concern!" (Deborah Phillips et al.); "Risks Remain" (Jay Belsky); "Infant Mental Health and Child Abuse and Neglect: Reflections from an Infant Mental Health Practitioner" (Jeree Pawl); "Doll Play of Failure to Thrive Toddlers: Clues to Infant Experience" (Claire Haynes-Seman and Joan Suzuki Hart); "Abuse and Neglect in the Earliest Years: Groundwork for Vulnerability" (Brandt Steele); "Psychotherapy of the Violent Offender: A Recapitulation of Infant Development" (H. Joseph Horacek); "The Effectiveness of Crisis Intervention in Working with a Young Mother and Her Four Preschool Children" (Sarah Landy); "The Application of a Transactional Risk Model to Intervention with Multi-risk, Maltreating Families" (Dante Ciccheti and Sherre Toth); and "Toward Tenacity of Commitement: Understanding and Modifying Institutional Practices and Individual Responses that Impede Work with Multi-problem Families" (Barbara Fields). Issues typically also include publication reviews, program notes, and conference information. (DB)

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Infant Day Care: A Cause for Concern?

by Jay Belsky
The Pennsylvania State University

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Every essay on day care invariably begins with an opening comment regarding the social changes we have all witnessed during the past two decades. These changes—and their consequences vis-a-vis child care—are not news to readers of *Zero to Three*. One point worth noting, though, involves the rapid growth of employment not simply for women in general, or for those with young children in particular, but specifically for those with infants under one year of age (Klein, 1985). Not only is this the fastest growing sector of the employed-mother labor market, but the most recent statistics reveal that virtually one of every two women with a child under one year of age is now employed (Kamerman, 1986).

When [illegible] comes to considering the care which the infants of these mothers receive, it is imperative that we understand what we are talking about—and we are not, for the most part, talking about day-care centers. The overwhelming majority of infant care is provided in private homes—in 1982, a full 77%; not even 10% of infants whose mothers are working are to be found in centers (Klein, 1985). Moreover, tremendous diversity characterizes infant care in private homes. The most recent statistics describing the care of children under three years of age reveal that (as of June, 1985) 45% of these infants and toddlers were cared for by a relative (27% in own home, 18% in relative's) and 24% were cared for in family day care (Kamerman, 1986)

The diversity of arrangements that constitutes the reality of infant care in America today poses serious challenges to scientists who seek to discern the "effects" of day care on young children (to say nothing of its effects on their families). After all, families that use day care and those that do not may differ from each other in a myriad of ways, as families that use one type of care may differ from families using another type. Thus, the very concept of "effects of day care" appears misplaced, as between-group comparisons are plagued with a host of confounds that cannot be teased apart by most statistical or design controls. How are we to know whether so-called "day-care effects" are effects of day care or of being in families that have others share in the rearing of their infants? We must recognize that comparisons between day-care-reared and home-reared infants represent comparisons of early development in

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contrasting ecologies rather than "effects" of day care in the pure, causal, or experimental sense of the word.

Having cautioned the reader regarding the nature of conclusions that can be drawn from research regarding any "effects" of day care, I feel compelled to make a final introductory comment before proceeding to consider the developmental correlates of nonmaternal care initiated in the first year of life. This has to do with the political and personal contexts in which research on day care is conducted, reported, and discussed. Day care is a very emotionally-charged topic, especially when we are talking about babies. The moment a poor scientist stumbles on evidence suggesting a potentially negative effect of day care and reports it, a host of ideologues are raising questions, criticizing methodology, mounting ad hominem attacks, or simply disregarding the data entirely in their pronouncements. As I went to testify before Congress in the fall of 1984, people warned me not to raise concerns about infant day care because of their political implications. I decided, however, to behave as a scientist and present the evidence as I regarded it. My own personal sense is that few individuals are truly open-minded about infant day care. Politicians, like many others, are either for day care or against it: they sift through the research looking for ammunition for their arguments while finding fault with, and thus dismissing, any evidence that reads the other way.

> *Day care is a very emotionally-charged topic, especially when we are talking about babies.*

Scientists, of course, are susceptible to similar biases, however much we try not to be. This fact was brought home to me recently in a most vivid way as part of a correspondence with a colleague whose work on and opinions about day care I admire and respect immensely. In sharing with me her plans to carry out a meta-analysis of research bearing on the influence of day care on infant-mother attachment, this mother of a young infant in sitter care wrote to me that "I think historical and cross-cultural data can be used *to support the position* that shared caregiving, which is what day care is, is not detrimental to child development" (emphasis added).

Since holding a point of view, either consciously or unconsciously, and for whatever reasons, prior to the analysis of the evidence may involve a considerable risk of bias entering into the reading of such evidence, I feel it is important to make several facts clear about my circumstances: I am the father of two darling and demanding young sons who spent their entire infancies in the primary care of their mother and who did not start preschool (on a three half-day a week schedule) until they were 2½ and 3 years of age. Because I am not sure that this family reality of mine does not influence my reading of the scientific evidence, I share it here.

Concern with the development of infants in day care: A 15-year perspective

In the early 1970s, prevailing cultural attitudes led to the belief that exclusive maternal rearing, particularly during the early years, was essential for healthy psychological development. The principal organizing

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question of day care research thus became "Does rearing outside of the confines of the family in a group program adversely affect intellectual, social and, especially, emotional development?" This specific interest in the developmental consequences of day care, and particularly a concern for negative effects, derived from policymakers' and scientists' feeling of obligation to protect the public from harm. If day care proved detrimental to child development, they would not want to be in the position of advocating policies to promote, or even support, the group-rearing of young children beyond the confines of the family. If such early rearing experience was found to disrupt the normative course of early childhood, the best interests of the public would be served if mothers or fathers did not work unless it was absolutely essential.

When I reviewed the literature on the effects of day care in 1977 (Belsky & Steinberg, 1978) and again in 1980 (Belsky, Steinberg, & Walker, 1982), I found little if any evidence of detrimental effects of nonmaternal child care on infant development. This was especially the case for model, university-based, research-oriented programs. Only one conclusion could be reached: infant day care *need not* disrupt the child's emotional development.

In terms of most day care research, emotional development has been conceptualized in terms of the quality of the affective tie linking child to mother. This focus upon the attachment relationship was based upon a great deal of theory suggesting that the emotional security which this bond promoted in the child would affect his/her future well-being, particularly his/her feelings about self, others, and capacity to form relationships. In order to study the effect of day care on the security of the infant-mother attachment relationship, researchers employed the Strange Situation, a laboratory procedure in which the baby is subjected to a series of brief separations and reunions with mother and stranger and his/her behavior is observed.

In 1977, only one conclusion could be reached: infant day care need not disrupt the child's emotional development.

Early studies of infant day care which employed this procedure or some variant of it revealed not only that day care infants were as likely to get distressed as home-reared children when confronting a stranger or being separated from mother, but also that they clearly preferred their mothers as objects of attachment. Caregivers, then, were not replacing mothers as the source of infants' primary emotional bonds, and this was, and still is, regarded as a good thing—especially since the evidence also indicates that day-care infants can and do form healthy affectional ties to individuals who respond to their needs in their day care environment.

Florence Sharp

It is of special significance that in all the initial work done on infant day care, and on which the preceding conclusions were based, attention was paid to whether or not the infant became distressed upon separation and whether or not s/he approached and interacted with a strange adult. In the years which *followed* the first wave of studies of infant day care, it became abundantly clear that the most revealing and developmentally meaningful aspect of the infant's behavior in the Strange Situation was his/her orientation to mother upon reunion following separation, something which simply had not been considered in the early studies. Indeed, attachment researchers now distinguish between three types. Infants who positively greet their mothers (with a smile or by showing a toy) and/or who approach mother to seek comfort if distressed are characterized as having secure attachments. Those who fail to greet mother (by averting gaze) or who start to approach mother but then turn away are considered to be anxious-avoidant in their attachment; and those who seek contact yet cannot be comforted by mother and who cry in an angry, petulant manner or hit away toys offered by mother are considered anxious-resistant in their attachment relationship.

In numerous studies these patterns of secure and insecure attachment relationships have been found to be predictive of individual differences in later development, such that those infants who are characterized as having secure attachments look, as a group, more competent than their agemates whose attachments to mother are characterized as insecure (Bretherton, 1985; Lamb et al., 1985). All of this is not meant to imply that the child's future development is solely or unalterably determined by the nature of the infant-mother attachment bond, but merely to indicate why a focus upon reunion seems so important to understanding the developmental correlates of infant day care.

Another Look at the Evidence

In the time since my initial reviews of the day care literature, a number of additional investigations have been reported which not only have raised concerns in my mind about the developmental correlates of nonmaternal care initiated in the first year of life, but have also led me to re-examine earlier research. It is not my intention to provide an exhaustive summary of my current reading of the evidence (see Belsky, 1986), but rather to outline my thinking.

In my 1980 review, only a single investigation raised any real concern in my mind regarding infant care. Vaughn and his colleagues (1980), studying a sample of low-income caucasian women and their firstborn in the Minneapolis-St. Paul area, found that infants who were reared in what appeared to be low quality, if not frequently changing, child care arrangements were especially likely to show a particular pattern of attachment to mother if they had been enrolled in care in the first year of life. Specifically, they were disproportionately likely to display a pattern of avoidance in which they refused to look at or approach mother when reunited with her after brief separations in the Strange Situation paradigm.

In addition to the Minnesota study which first raised some concerns in my mind, several other findings in the literature in 1980 *could* also have been regarded as *potential* evidence of negative effects. For example, Ricciuti (1974) found that at one year of age day-care-reared infants cried more in response to separation than did a home-reared group. In another study of a very small sample, Rubenstein, Howes, and Boyle (1981) observed that children who were in day care during the first year of life had more temper tantrums than those cared for at home by mothers on a full-time basis. In my writings I have consistently, and I believe wisely, cautioned against overinterpreting such group differences, particularly because they emerged in a context in which virtually all other measures revealed no differences. We should look for trends and patterns, I counseled, and not be swept away by a single variable, especially when other studies fail to discern a similar day care-home care difference that could be interpreted as an effect of day care.

When it came time for me to review the literature again in 1982, I found that a few more studies revealed what could conceivably be viewed as evidence of negative effects of day care on the development of infants (see Belsky, 1984). In fact, each time I have gone back to my files of day care reports, first to prepare my congressional testimony in 1984 and then to prepare a talk to the American Academy of Pediatrics in 1985, I have found that disturbing evidence keeps accumulating. I am not talking about a flood of evidence, but at the very least a slow, steady trickle.

Consider first the fact that, at the same time that Vaughn and his colleagues (1980) were following their Minneapolis sample at two years of age and Farber and Egeland (1982) were discerning no significant differences between day-care and home-reared infants, another study provided further evidence of a pattern of avoidance associated with early substitute child care. This study of middle-class infants in Michigan revealed that those babies who began day care (in a variety of arrangements) in the first year of life displayed greater avoidance of their mothers in the Strange Situation separation procedure (Schwartz, 1983) at 12 months of age than did home-reared infants. This heightened avoidance was also chronicled by Wille and Jacobson's (1984) investigation of 45 18-month-olds from the Detroit area; when studied with their mothers in the Strange Situation, those children displaying insecure-avoidant attachment patterns were found to have experienced more than three times as much extra-familial child care as their securely attached (to mothers) counterparts (15.9 hours/week versus 4.5 hours). And, in still another study, this one of affluent families in the Chicago area, Barglow (1985) found higher rates of avoidance as well as decreased rates of proximity-seeking and contact maintenance for those infants experiencing good quality, stable "other-than-mother" care in the home than for a comparison group whose mothers did not work outside the home during the baby's first year.

Each time I have gone back to my files of day care reports, disturbing evidence keeps accumulating.

These newly emerging data, it is of interest to note, turn out to be quite consistent with trends in the more general day care literature concerning preschoolers. As Clarke-Stewart and Fein (1983) observed in their comprehensive review of the evidence appearing in the most recent edition of the authorative *Handbook of Child Psychology*,

> "children in day care are more likely than children at home to position themselves further away from mother, and to ignore or avoid mother after a brief separation. The difference is not observed in every child or every study, but the consistent direction of the differences is observed." (p. 948)

There is, then, an *emerging* pattern here in which we see supplementary child care, *especially that initiated in the first year*, whether in home or in centers, sometimes associated with the tendency of the infant to avoid or maintain a distance from the mother following a series of brief separations. Some, as I have already indicated, contend that such behavior reflects an underlying doubt or mistrust about the availability of the mother to meet the baby's needs and, thus, an insecure attachment. Moreover, since it is known that heightened avoidance of the mother is related to a set of developmental outcomes such as noncompliance and low frustration tolerance which most developmentalists would regard as less than desirable, some are inclinded to conclude that the quality of the mother-child bond and thereby, the child's future development may be jeopardized by nonmaternal care in the first year of life.

Other scientists read *the very same evidence* in a *very different way*. Even though they observe the same pattern of avoidance among infants in day care, they interpret this not as a deficit or disturbance but rather as positively adaptive and possibly even precocious behavior. Since day care infants experience many separations, they reason, it is sensible for them not to orient toward mother. In addition, because the tendency for children as they get older is to remain more distant from their parents, the avoidance of mother among day-care-reared 12-18 month olds is seen as evidence of early maturity:

> "In children receiving care exclusively from mother, avoidance may be a pathological response reflecting an interactive history with a rejecting mother, while for children in day care greater distance from, or ignoring of, mother at reunion may be an adaptive response reflecting a habitual reaction to repeated daily separations and reunions. In these latter children, greater physical distance from mother and apparent avoidance may, in fact, signal a precocius independence." (Clarke-Stewart & Fein, 1986, p. 949)

Which interpretation is correct? I concur with Clarke-Stewart and Fein (1983) that "there is no way to determine at this point if the apparent avoidance of mother observed in day care children in *some* studies is a disturbed or adaptive pattern" (p. 949; emphasis in original). But this very uncertainty leads me to wonder about the meaning of other data regarding the subsequent social development of those children who experienced nonmaternal care in the first year.

The Long Term Development of Day-Care-Reared Infants

The very first investigation of the social development of preschoolers with infant day-care histories involved the developmental follow-up at three and four years of age of children who began nonmaternal, group care toward the end of their first year at the Syracuse University Infant Care Center (Schwarz et al., 1974). When compared to a group of children reared exclusively at home until entering a preschool day-care program, those with infant care histories were found, four months after entering the preschool, to be more physically and verbally aggressive with adults and peers, less cooperative with grown-ups and less tolerant of frustration. When the children from the Minnesota studies, which first linked infant care with insecure-avoidant attachment, were studied at two years of age, somewhat similar results emerged. Although Farber and Egeland (1982, p. 120) were led to conclude on the basis of their analysis of the problem-solving behavior of the Minnesota toddlers that "at two years of age the effects of out-of-home care were no longer striking" and "that the cumulative adverse effects of out-of-home care were minimal," careful scrutiny of the data leads a more cautious reader to a different conclusion. Not only was it the case that toddlers whose mothers began working prior to their infant's first birthday displayed significantly less enthusiasm in confronting a challenging task than did children who had no day care experience, but it was also the case that these day-care-reared infants tended to be less compliant in following their mothers' instructions, less persistent in dealing with a difficult problem, and more negative in their affect. A more thorough analysis of these same data by Vaughn, Deane, and Waters (1985) further revealed that although 18-month attachment security was a significant adavantage to the children who were home-reared as infants when studied at 24 months, the securely attached infants who had entered day care in their first year looked more like toddlers with insecure attachment histories (from home- and day-care groups) than like home-reared children with secure infant-mother relationships. That is, early entry to day care in the first year appeared to mitigate the developmentally beneficial effects of a secure attachment that is so often noted in studies of home-reared middle- and lower-class children.

The child development outcomes associated with early entry into supplementary child care are similar to those undesirable development outcomes correlated with early insecure attachment to mother.

What is most notable about these findings from the Syracuse and Minneapolis studies, and even from other investigations (see below), is that the very child development outcomes associated with early entry into supplementary child care are the same as, or at least similar to, those that have been implicated in the attachment literature as the (undesirable) child development outcomes correlated with early insecure attachment to mother. Indeed, the tendency of the early day care infants in the Minneapolis and Syracuse studies to be less compliant at two years of age leads me to wonder whether I was too ready in early reviews to explain away Rubenstein, Howes, and Boyle's (1981) similar findings regarding the significantly more frequent temper tantrums and decreased compliance of 3½ year olds who had been in supplementary care in their first years.

Other studies in the literature which do not focus specifically on attachment also raise concerns about infant day care. These studies report results that are not inconsistent with the notion that infant care *may* promote anxious-avoidant attachments. For example, a study conducted in Bermuda involving virtually all two year olds on the island found that "children who began group care in infancy were rated as more maladjusted (when studied between three and five years of age)

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than those who were cared for by sitters or in family day care homes for the early years and who began group care at later ages" (McCartney et al., 1982, p. 148). These conclusions, it is important to note, were based upon analyses which controlled for a variety of important background variables, including child's age at time of assessment and mother's IQ, age, and ethnicity. In a retrospective investigation of eight to 10 year olds who varied in their preschool experiences, Barton and Schwarz (1981) also found that day care entry prior to 12 months was associated with higher levels of misbehavior and greater social withdrawal, even after controlling for the educational level of both parents.

Finally, and perhaps most noteworthy, are results emanating from a longitudinal investigation of kindergarten and first graders reared since they were three months old in an extremely high-quality day care center at the University of North Carolina. Comparison of these children with others reared for varying amounts of time in nonmaternal child care arrangements initiated sometime after the first year of life revealed that children who received center-based care in the first year of life, in contrast to those receiving care any time thereafter, were rated:

> ". . . as more likely to use the aggressive acts hit, kick, and push than children in the control group. Second, they were more likely to threaten, swear, and argue. Third, they demonstrated those propensities in several school settings—the playground, the hallway, the lunchroom, and the classroom. Fourth, teachers were more likely to rate these children as having aggressiveness as a serious deficit in social behavior. Fifth, teachers viewed these children as less likely to use such strategies as walking away or discussion to avoid or extract themselves from situations that could lead to aggression" (Haskins, 1985, p. 700).

Conclusion

What are we to make of the evidence just summarized? The first point which must be made before drawing any conclusions is that not every study of infant day care reveals a heightened risk of insecure-avoidant attachment or of aggression, noncompliance, and disobedience. Nevertheless, it is clear that if one does not feel compelled to draw only irrefutable conclusions, a relatively persuasive *circumstantial* case can be made that early infant care *may* be associated with increased avoidance of mother, *possibly* to the point of greater insecurity in the attachment relationship, and that such care *may* also be associated with diminished compliance and cooperation with adults, increased aggressiveness, and possibly even greater social maladjustment in the preschool and early school-age years.

What is most noteworthy about these very *possibilities* is that they are *strikingly* consistent with basic theoretical contentions of attachment theory. It is certainly not inconsistent with attachment theory that repeated separations in the first year of life, as routinely associated with day care usage, might affect the emerging attachment relationship, and even disturb it from the standpoint of security (or at least avoidance). Further, the theory clearly assumes that avoidance reflects some doubt on the part of the infant with respect to the availability and responsiveness of the mother and may well serve as a coping strategy to mask anger. Finally, the theory clearly assumes that an avoidant attachment places the child at risk (probabilistically) for subsequent social difficulties, with diminished compliance and cooperation, increased aggressiveness and even maladjustment being, to some extent, expectable outcomes (or at least subsequent correlates).

The point of this essay, and my reason for writing it, is not to argue that infant day care invariably or necessarily results in an anxious-avoidant attachment and, thereby, increased risk for patterns of social development that most would regard as undesirable, but rather to raise this seemingly real possiblity by organizing the available data in such terms. I cannot state strongly enough that there is sufficient evidence to lead a judicious scientist to doubt this line of reasoning; by the same token, however, there is *more than enough* evidence to lead the same judicious individual to seriously entertain it and refrain from explaining away and thus dismissing findings that may be ideologically disconcerting. Any one who has kept abreast of the evolution of my own thinking can attest to the fact that I have not been a consistent, ideologically-driven critic of nonmaternal care, whether experienced in the first year of life or thereafter. Having struggled to maintain an open mind with respect to the data base, so that the evidence could speak for itself, I know how difficult a task this is. I am well aware, too, that my gender and the more or less traditional nature of my family structure could bias my reading of the evidence.

It is certainly true that the very same evidence that I have presented for purposes of raising concern (not alarm) and encouraging others to reconsider the developmental correlates of infant day care could be organized in a different manner. This not only should be, but has been done, and very well indeed (Clarke-Stewart & Fein, 1983; Hoffman, 1983; Rubenstein, 1985). It is also the case that virtually any one of the studies cited above could be dismissed for a variety of scientific reasons. But in the ecology of day care, perfect field research seems almost impossible; moreover, it would seem that the more perfect it is, the less generalizable it might be.

Infant day care refers to complex ecological niches. Any effects associated with care are also associated with a host of other factors.

This complexity inherent to infant day care research underscores a most important point that also cannot be sufficiently emphasized. When we find infants in care we are not only likely to find them in a variety of arrangements usually resulting from their mothers working outside of the home, but also for a variety of reasons and with a variety of feelings and family practices associated with these care arrangements. Thus, infant day care refers to complex ecological niches. This means, then, that any effects associated with care are also associated with a host of other factors. Thus, it would be misguided to attribute any effects associated with nonmaternal care to the care per se, or even to the mother's employment.

Not to be lost in this discussion, however, is the fact that the correlates of day care which have been chronicled (i.e., avoidance, aggression, noncompliance, withdrawal) have been found across a host of ecological niches and caregiving milieus. Thus, these "effects" or correlates of early supplementary care have been found in samples of impoverished (Haskins, 1985; Vaughn et al., 1980), middle-class (Rubenstein, Howes, & Boyle, 1981), and upper-class families (Barglow, 1985), and with children cared for in unstable family day care (Vaughn et al., 1980), high quality centers (Haskins, 1985; Schwarz, Strickland, & Krolick, 1974), poor quality (McCartney et al., 1982), and even in-home, babysitter care (Barglow, 1985). Such variation in the samples studied, yet similarity in the developmental outcomes associated with nonmaternal care in the first year, lead me to conclude that entry into care in the first year of life is a "risk factor" for the development of insecure-avoidant attachments in infancy and heightened aggressiveness, noncompliance, and withdrawal in the preschool and early school years. Under a variety of imaginable conditions, particularly pertaining to the quality and stability of the care arrangement, the temperamental vulnerability of the child, and the economic-social stresses to which the family is subjected, it seems likely that risk associated with early care would increase.

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Model Versus Modal Child Care for Children from Low-Income Families

by

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Karie (age 1 year, 11 months), a child abused at home, sits on the potty chair in the bathroom of the child-care center. The assistant sits on a chair blocking the doorway. "You just sit there until you go," says the assistant to the little girl. Karie sits looking very sad.

This scene, observed in a child-care center, was one of many distressing events recorded during approximately 1000 hours of observation of 100 two- and three-year-old children in centers serving primarily children from poverty families (Wittmer, 1985). I could contrast each disturbing interaction or event with a positive one, but the disturbing events tell a tale that must not be ignored—a tale of child care where one sees very well-intentioned but highly stressed, often untrained, and poorly paid caregivers; high-risk children with pressing needs; hopelessly high child-staff ratios; group size that is too large; and too few support services offered to children and their parents.

Eric (age 2 years, 2 months) sits at the paint table with paper, a paint cup, and a pencil with a string attached to it. The caregivers want the children to hold on to the pencil, dip the string in the paint cup, and paint on the paper. Eric crumples up his paper. The teacher says, "Oh, dear, Eric" in a disgusted voice. The caregiver says to another teacher in a voice loud enough for Eric to hear, "Eric needs to be demoted to the walker's room (the room for the 12- to 18-month-old babies), as she straightens up Eric's paint paper. Eric tries to put the string in the paint cup. He accidently knocks the paint cup on the floor. He crumples up his paper again. "Eric, don't" the teacher yells angrily. "Let me get you some orange paint" she says to him in a distressed voice. She leaves. Eric puts the painted string (covered with blue paint) in his mouth. A different teacher says, "Eric, please do not put paint in your mouth." Eric takes the string out of his mouth. Then he puts it back in again. "Eric, nasty," says the teacher. He removes the string again. He tries to pull the string off the pencil with his hands. He doesn't succeed, so he uses his mouth to get the string off. He chews on the string. He has paint all over his mouth. The teacher never gets him more paint, and finally he's removed from the paint table.

Children from low-income families are at risk for language and other learning problems, as well as social-emotional disturbances (Golden & Birns, 1976; Greenspan, 1981; Lally & Honig, 1977). These high-risk children almost uniformly attend modal child care as opposed to model child care. **Modal child care** is a term that was used by Belsky (1979) when describing the New York City child care programs studied by Golden et. al (1978). It is the mode, the customary, the primary means of child care. Modal child care occurs in unlicensed or in state licensed family day care homes and in licensed day care centers. Modal child care is what is available to the majority of low-income families in the United States. Low-income children's fees are subsidized in licensed family day care homes and in licensed centers.[1] Because each state determines the licensing standards for that state, standards and quality vary greatly.

Model child care is seen typically in university or university-connected centers. These centers provide child sensitive, developmentally enriching care, which can help to prevent or ameliorate the learning and relationship problems of children in poverty. Based on the needs of these children, model child care can consist of:

(1) Highly trained and well-qualified staff, including staff with training in special education, infant and toddler development, and the special skills required for work with abused and/or neglected children;

(2) A program is responsive to the individual child's needs and includes both a high level of positive adult-child interaction and communication and the availability of a range of interesting play materials which are developmentally appropriate;

(3) Small group sizes and low child-teacher ratios;

(4) Many opportunities for pre-and in-service training of staff;

(5) A method for assessing a child's need for special services;

(6) Parent education, including home visits, parent meetings, and parent involvement in the classroom;

(7) Support services such as health services (including medical and dental services), a social worker, and counselors for various problems and sophisticated mental health referrals.

In contrast, the modal child care provided for at-risk children sadly lacks these qualities—which are necessary if child care is to have a positive impact on development. Ridiculously high caregiver-child ratios in licensed child care are often enough to make high quality impossible.

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[1] Licensed child care for children from low-income families is funded by Title XX. The Title XX Social Services Block Grant provides federal assistance to states for support for child care services for poverty families. In 1977 $2.7 billion was given states on a 75%/25% matched basis to provide social services to families living in or near poverty. Of these funds, $800,000 or .03% was used for licensed center and family care. In addition, $200,000 was provided on a nonmatched basis, primarily for the purpose of upgrading day care based on federal regulation standards. In 1982, under the Reagan administration, there was a 25% reduction in social service funds. States are no longer required to match federal funds and are no longer required to allocate a specific portion of the funds for welfare recipients. These policies result in less money available for licensed child care just when there has been an increase in women working and an increase in poverty (McMurray, G. & Kozanjian, D., 1982).

In Arizona, for example, state regulations allow a ratio of 8 infants to one caregiver. Most states allow a caregiver to work with at least 10 toddlers. Any one who has tried to care for that number of infants knows how difficult, if not impossible, it is to wipe noses and change diapers in a nurturant way while providing a developmentally enriching program for the children.

Jerel (age two years, 4 months) stands up on a chair. The caregiver tells him to get down. He loudly asserts himself by saying, "No!!" The caregiver approaches him and he takes off running across the classroom. She catches him and yells at him. He hits at her. She sits on him and yells, "You don't need to think you're better than anyone else. You're going to learn to listen." He starts crying. She lets him up.

Most caregivers in modal child care are not required to have had training in a child-related field. Yet they are often working with developmentally delayed children and highly stressed families. More children are being court-ordered into day care because of abuse and neglect in their homes. In one licensed child care center in a large city in New York, 50% of the children have been identified as abused or neglected. Yet this center receives no special funds for training caregivers or providing the badly needed social support services.

Jayne (18 months) goes from teacher to teacher crying, hands held up (wanting to be picked up). The caregivers ignore her or tell her "No." She cries in despair and finally goes to a young high school boy who is temporarily assisting in the classroom. He looks to the head teacher and asks permission to pick Jayne up and comfort her. The head teacher says, "No, if we pick her up, she'll always want to be picked up." Jayne continues crying. Finally she drops to the floor and begins pounding her head on the floor. A teacher picks her up and sits her on a chair at a table. Jayne cries, screams, and kicks so hard the chair falls backwards, and Jayne hits her head on the floor. An assistant picks her up, puts her on her tummy on the assistant's lap, and pats her back. Jayne sobs herself to sleep.

There are many competent and caring teachers and directors who work in child care and those I have interviewed feel distressed. They express great frustration regarding the number of children in their care, the neediness of the children, the lack of opportunity to work with parents, the dearth of evaluation and referral resources for the children, the fact that more abused and handicapped children are being placed in their care, the lack of special services, and of course, their own low pay and low status.

Bobby (age 2 years, 3 months) walks to the block area. He starts taking blocks off the shelf. He then drops them (seemingly on purpose) on Glenn who is sitting on the floor. Glenn cries. Bobby gets more blocks and approaches Glenn from behind while attempting to hit him. Glenn moves away. Bobby then drops a block on Tina's back and runs away. Tina cries. Bobby climbs up on a play ironing board and hits the wall with a block. He spies Glenn, hurries down, and yells, "Hey, you" angrily to Glenn. Glenn walks away. Eric hits a cardboard box with a block. Melvin, another boy approaches Bobby and Bobby hits at him.

"Go to jail. You're bad. You just stay in jail until I tell you to get up," yelled the assistant teacher as she led Wayne (age 2) out of the gym and made him sit against the wall as punishment for some misdeed he had done in gym. He sits angrily glaring at the assistant.

When I first began observing in child-care centers, I was angry at caregivers for the inappropriate behavior I saw occurring. Then I realized that their behavior reflects the general failure of society to value child care as a "prime opportunity for primary prevention" (Caldwell, 1970). If licensed child care were seen as an early opportunity for giving children a "Head Start," thus regulatory standards could be written and funds allocated by federal, state, and local governments as well as by a multitude of other agencies, to provide a humane and developmentally enriching program for these young children who attend licensed child care. Still, a significant problem would still remain. The majority of children from low-income families whose parents are employed attend *unlicensed home care*. Norlander (1986) argues that the system casts a blind eye on unlicensed providers, thus presenting serious obstacles to those who are seeking to make quality family day care available. No one really knows what is happening to poverty children in these child care settings.

Edward Zigler (1982), in the foreward to his book *Day Care-Scientific and Social Policy Issues*, states, "By far the thorniest issue in day care, however, is the fundamental issue of quality versus cost. As Ruopp and Travers (1982) have pointed out, 'After a decade of research, quality day care can to some degree be both defined and delivered . . . The question is: Who will pay the piper and how much will he be paid?'"

Yet the piper must be paid somehow, or many children will continue to be lost in this world of low-quality child care that propels them down a path toward low achievement and unrewarding human relationships.

Low-income families have no choice between modal and model child care. Although many are part of the labor force, struggling to provide for their children, their income is so low that they still must use subsidized, modal care (and fear the consequences of losing their eligibility). Society has an opportunity and a responsibility to provide more than modal child care offers. The cost-effectiveness of comprehensive early intervention programs has been proven (Barnett, 1985). The human costs of *not* providing high quality care are evident all around us. Neither society nor the children can afford such costs. All our children need and deserve the best care we can provide.

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"The Sooner the Better Project": Involving Parents and Day Care Staff in the Identification and Treatment of Developmental Delays and Disturbances in Infants and Toddlers

by
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What happens when an infant or toddler in day care has undiagnosed, unmet developmental needs? First, the caregiver may experience difficulty—a child may require extra assistance, may withdraw or act out aggressively, may arouse feelings of frustration or ineffectiveness. Second, the parents, who may be experiencing similar feelings of inadequacy in their relationship with this child, may react to the "public" exposure of the child's problems in the day care setting by ignoring the problem or with increasingly negative feelings toward the child. Third, the child, perhaps coping already with negative experiences and frustration related to the developmental issues involved, may experience anxious, negative responses from adults both at home and in the day care setting.

At the same time, an infant-toddler day care setting has tremendous potential to serve as the source of screening, evaluation, referral, follow-through, and emotional support for very young children with special needs and their families. Day care staff observe children 8-10 hours a day, five days a week as they eat, sleep, play, get tired, get dirty, get upset and are comforted. Trained and experienced caregivers are not only in an excellent position to observe and identify children whose behavior and development are of concern, but they also have an opportunity in their daily interactions with parents to observe disturbances in early parent-child relationships.

The Sooner the Better project (TSTB) is an innovative initiative that was developed in response to the frustrations and expressed needs of day care personnel who recognized that developmental day care, while promoting the well-being of most children and families, was insufficient to meet the special needs of very young children experiencing developmental delays and disturbances, and the needs of their families. Day care staff could recognize problems but lacked the training to diagnose them and, more importantly, to develop treatment plans. At the same time, they knew that the lack of publicly funded programs for disabled and at risk infants and toddlers often meant that children, families, and caregivers would be forced to "wait it out" until the child became three. TSTB is designed to tap the enormous power of caregivers, parents, and infant mental health professionals working together—within the day care setting—on behalf of the child.

TSTB is based in Baby Toddler Nursery, a child care program for children from four months to three years of age, sponsored by the Infant Welfare Society of Evanston, Illinois. Three-quarters of the 61 children enrolled are from low-income families. The center is not university based, but funded through a combination of public (Title XX) and private sources. Ratios of caregivers to children range from 1:4 for infants to 1:7 for two-year-olds.

The professional caregivers at the center come from a variety of backgrounds, with well over half living in the community served. Most have received their training at local colleges; all have completed some courses, and a few have earned an A.A. degree. Staff of TSTB—all working part-time on the project—include the director and assistant director of the day care center, a psychologist, a clinical psychology graduate student, and a social worker from the Community Coordinated Child Care (4C) agency.

Expanding professional competencies of infant-toddler caregivers

Initial TSTB efforts included an assessment of caregivers' knowledge of what delays and disturbances look like in children under three, what infants need to experience in their relationships with adults in order to develop optimally, and what problems in parent-child relations look like in the earliest years. Staff designed two inservice programs that focused on: 1) the psychosocial needs of young children in group care and 2) caregiving approaches for supporting development of communications and language skills. Some caregivers also attended a class on the exceptional child offered through the local community college.

Interestingly, we found that communication of information itself resulted in few referrals for evaluation by caregivers for the children in their charge. They told us of their concerns that a referral of, for example, a child with delayed language would reflect poorly on their own "teaching." Referral of a child exhibiting depressed, somber affect, on the other had, might be

seen as intrusive into the parents' "personal life." TSTB staff recognized the need to develop a relationship of mutal trust with caregivers, working with them individually or in teams in their own classrooms. This allowed us to understand better the caregivers' experience of the child and to communicate respect for their professional competence through collaborative efforts to observe, evaluate and plan for the child's special needs.

It has been continuous work around the needs of individual children that has contributed most to furthering development of caregivers' clinical observation skills, changes in attitude about infants' and toddlers' need for affectively involved and responsive care, and well-deserved professional pride in having observations respected and ideas incorporated into treatment plans for special needs children. We also saw caregivers generalizing new attitudes and patterns of behavior to their interaction with other children.

"Freeing up" caregivers

TSTB emphasized that caregivers needed to be allowed time to work individually with special needs children. This process allowed them to experience such a child in a new way—not just as demanding, but as needing special approaches. Caregivers experienced themselves in a new way as well—not only as making snacks, changing diapers, and picking up cots, but as being affectionate, responsive and interested in what an individual child can do, what he is trying to say. The program allowed time for responsive care. Caregivers were "freed up" also to spend time with parents, enlisting them to the fullest extent possible in planning and providing care for their child.

Clinical services research

In addition to TSTB's clinical services, a research component was begun this year in order to evaluate the efficacy of providing screening and making preventive intervention services available for all families with children under three in group care. Using data from a parental stress questionnaire, we will be looking at the relationship between parental stress and developmental delays and disturbances in this population. Preliminary data indicate good sensitivity and specificity for the TSTB risk assessment. Indications are that day care intake procedures that include developmental screening or assessment, along with inquiry about the level of stress and social support experienced by families will assist day care staff in recognizing the special needs of infants and parents in their programs and the role that the day care program may provide in addressing those needs.

Two years with Brian

A description of TSTB's work with Brian and his parents suggests the benefits provided by this project for the child, for the family, and, no less importantly, for professional caregivers.

Brian was a healthy, active, curious and well-functioning infant until he contracted hemophilus influenza which developed into bacterial meningitis. He was eight months old at the time. A bright-eyed child with dark, wavy hair, he had just been enrolled in Baby Toddler Nursery when he became ill and was hospitalized for ten days. Returning to the nursery after two weeks at home, he was completely changed. Once robust and energetic, Brian was listless and sickly. Able to crawl and pull himself up to stand at eight

months, at nine months he could not sit unsupported and had little control of his head and neck muscles. His organizational and self-regulating abilities had regressed, and his affect had become somber and depressed. Formerly friendly and affectionate, vocalizing and socially responsive, he now averted his gaze and arched away from comforting or cuddling. Perhaps most devastating, the results of a brainstem auditory evoked potential showed no response in the left ear and diminished ability to hear in the right ear.

While Brian made gains both physically and emotionally over the next few months, it became clear to day care center staff that complete spontaneous recovery was unlikely. The report from the developmental assessment conducted at 11 months by the center's consulting clinical developmental psychologist described Brian as lying on his back in the infant room when she came to get him for testing, his color grey or dusky, his affect dampened and somber. He appeared sick and listless. Brian was alert, however, and watched intensely the activity of the others in the room. Asked by the psychologist for their observations and experience of Brian over the prior few weeks, center caregivers described him as lying on his back unless held, often crying or wearing a distressed expression, and being extremely difficult to comfort. When they looked at him, he would quickly avert his gaze. They felt that he was fragile and needy, but they also felt that they didn't know what to do to help him.

Results of the Bayley Assessment indicated an MDI of 71 and a PDI of 58. Some of Brian's failures were on items requiring vocalization or auditory skills, and others required a higher energy level than Brian was capable of at the time. His psychomotor functioning was greatly impaired, and though he did demonstrate age-appropriate fine motor skills, the quality of his movements were of concern, with stiffening and arching noted. While Brian was quiet, wary and withdrawn when the assessment began, he appeared to be able to make use of the psychologist's holding him, and focusing his interest with quiet enthusiasm and positive affect did not overstimulate him. He was able to become more involved with the test materials. A very bright child, Brian was able to complete age level items that did not tax his physical energy level or require auditory comprehension. He brightened when he built a tower of two cubes, and he became involved in reciprocal, responsive play with the psychologist.

By his first birthday, however, Brian still had a somber demeanor, had difficulty with head and neck control, and was able to sit unsupported for only brief periods. Most serious, he did not appear to respond to sounds or to spoken language.

Not surprisingly, it was difficult for Brian's parents to accept his disabilities. In contrast, it was difficult for daycare staff to understand and accept his parents' reluctance. While parents of a special needs child have very deep needs which are both emotional and practical, caregivers' needs are largely practical, having to do mostly with providing care and promoting development. In Brian's case, this difference was accentuated because the parents were coping with the loss of their healthy infant, while caregivers were emotionally involved only with the child he had become.

Since the initial evaluation, the extent and nature of Brian's hearing disability remain unclear. Audiograms and other tests have indicated borderline normal hearing (sufficient for speech development), but Brian continues to be unresponsive to spoken language. His parents maintain that he can hear and are determined that he use oral language exclusively. While they have cooperated in learning sign language, they primarily use spoken language in their interactions with him. Brian's speech therapist, on the other hand, wants him to learn sign language simultaneously with oral language, on the theory that sign language will provide him with more communicative ability more quickly, as well as giving him the construct of "language", which may help him to learn speech. Brian in fact has learned sign language quickly and uses it well, now teaching his caregivers new words. He can also initiate communication and express his growing autonomy: recently, in response to his caregiver's sign to sit, Brian vehemently made the sign for "walk."

To understand Brian's parents' perspective better, it is important to know that during the period of his illness and initial recovery they were also struggling to regain their equilibrium. They had just completed an interstate move and dual career changes when Brian became ill. Particularly for his mother, the loss of Brian as a healthy, responsive, competent infant was very difficult, and the experience of Brian as ignoring and uncooperative left her feeling frustrated and ineffective.

In the two years since Brian's illness, his parents have come to accept his disabilities to a significant degree. Their interaction with their son is far more positive and affectively attuned than formerly. He seeks comfort and approval from them, and they have come to be proud of his achievements, even in learning sign language.

Another dimension of this experience for Brian's caregivers was the opportunity for professional growth. Because of thier work with Brian, they were receiving consultation from, and working with, other professionals. They were helped to understand Brian's needs, which in turn helped them to avoid feelings of rejection and frustration. They were given practical suggestions for structuring his environment and for helping to promote his optimal development. Relieved of regular caregiving responsibilities for short periods in order to work alone with Brian, they helped him learn that adults can be expected to be responsive. In many ways, their experience was one of personal and professional growth.

The role of the day care center as a whole through these two years has been five-fold: 1) providing a developmental clinical assessment of Brian's strengths as well as areas of compromised functioning; 2) assessing Brian's parents' resources, coping abilities, relationship with Brian, and personal needs; 3) carrying out therapeutic plans developed for Brian, especially around communication skills; 4) coordination of

evaluation and services of a number of agencies and private providers; and 5) serving as a source of interested, available, and empathic support for parents. This last function has included exchanging anecdotes about Brian and his accomplishments, listening to his parents' frustrations and triumphs, reflecting on and interpreting feedback from other professionals, problem solving, developmental guidance, and encouragement. The day care center has proven to be an ideal source of support, particularly because of the opportunity for daily contact between parents and professionals who have an obvious involvement with the child. Because contact is so frequent, it is at times casual. Because it is so readily available, it does not add another "appointment" to an already heavy schedule. The daycare center supports both Brian and his parents in ways that more traditional services for infants and families facing developmental problems may find difficult to achieve.

Therapeutic Childcare at Merrywood School

by Maxine Siegel

Infants and toddlers who are disabled or at risk of developmental delay are also highly vulnerable to abuse and neglect. How can we best meet the needs of these children and their families?

Although early childhood educators and childcare workers have often been overlooked as resources for this population, in fact an appropriately staffed and individualized therapeutic day care program can offer unique opportunities to protect and support such children and families.

Merrywood school in Bellevue, Washington has served developmentally disabled infants and toddlers and their families for more than a generation, under the auspices of the state's Division of Developmental Disabilities and Crippled Children's Services. We felt that our expertise would make it relatively easy to serve abused and/or neglected children of the same age, and in 1984 we responded to a state of Washington Division of Children's Services request for proposals. The result is Therapeutic Childcare, a program designed for abused or neglected children who are referred by Child Protective Services in order to keep the family intact, protect and nurture the child, and counsel and closely supervise parents.

Only ten children are enrolled in Merrywood's child care program. A maximum of eight are scheduled to attend on any given day. Of these eight, four are non-handicapped and four are developmentally disabled. Because it is desirable for young children with mild impairments to be enrolled in community daycare, the developmentally delayed children enrolled in our specialized program are moderately to severely involved. Three child care staff members serve these eight children, two staff at any given time.

Only three of the eight children who can be either non-handicapped or developmentally delayed, are Child Protective Services referrals for therapeutic day care. Since the families of abused or neglected children tend to be dysfuntional, loading the full day program with such children overly stresses staff. With an amalgam of children's abilities and levels of family functioning represented in the program, however, staff can give the attention they feel necessary to the potentially abusing/neglecting parents and maintain other levels of interaction with better functioning families of handicapped or non-handicapped children in the group. Staff are also more able to respond to the demanding daily care needs of therapeutic day care children: these may include attention to diaper rashes, bathing, monitoring illness, feeding and coping with behavior problems. Most importantly, however, all parents and children in the school serve as incidental models for one another across the boundaries of disablilities, family characteristics, and ages.

The three therapeutic child care students are each enrolled five days a week in day care. They attend from six to ten hours per day. Because the full spectrum of special education and counseling components is available, therapeutic day care participants may be involved in whatever menu of services seems most appropriate and for whatever frequency, intensity and duration seems indicated. Children use the day care classrooms at Merrywood as home base for naps, meals and "down time." They then go from there to whatever classroom or therapy services are in their plan. This model provides both consistency of staffing and flexibility to choose among program components. The Merrywood School program also makes an effort to match parents' needs with particular staff talents.

We encourage parents to bring their children to school because they can then spend some time in the program, speak with school staff informally, and again meet other parents in the school. Because non-day care children come to Merrywood for specific classes or therapy only, many families relax in the parent lounge, observe class from a one-way mirror, and chat with one another. When therapeutic child care parents join them, they benefit from the casual modeling of appropriate parenting techniques: separating from children at the beginning of the school day, greeting them after class, behavioral modification, even supervision in the parking lot and use of car seats. They are able to see what toys, skills, and activities are appropriate for their children and get a great deal of positive feedback from staff. When parents do not transport their children, staff do so in private cars equipped with car seats. They send notebooks back and forth daily with progress reports, art work, and generous praise for both parent and child; parents say they are eager for the feedback.

Merrywood also assigns each therapeutic day care family to a case manager. To avoid overstressing any one professional, this role is divided among staff and is *not* the responsibility of the hands-on child care worker. A social worker serves as the key contact with one family; a second is served by his classroom teacher and a third by the program coordinator. These professionals meet with families at least weekly to discuss behavior management, child development and other issues. They are also the principal liaisons with Child Protective Services, Public Health physicians, and other resources.

Case vignettes

The program for the A's, whose developmentally delayed year-old son Philip exhibited failure to thrive and severe eating problems, involved attending hour long therapy sessions twice weekly with their child, meeting with the social worker weekly, playing with their son daily on the Merrywood grounds, and several days of volunteer work each week in her son's special classroom for Mrs. A. Philip was enrolled in day care while living with foster parents, and the parents' daily visitation was supervised at Merrywood. Because feeding was such an enormous problem, the A's initially came in at meal time to work with staff in feeding Philip. We soon noticed, however, that this was too stressful a period for both child and family. We backed off, let staff feed the child and encouraged Mom and Dad just to come and play daily—a far less anxiety producing and more reinforcing activity. Gradually the parents increased their involvement and learned new skills and Philip returned home. Today he is still enrolled at Merrywood, but in the developmental disability program, rather than in therapeutic day care. We continue to monitor his health and development and to provide physical and speech therapies as well as special education. After an initially hostile response to the program, his parents worked hard and were extremely cooperative. The medical and social service community and an excellent foster family also did their parts to achieve this success.

George is the developmentally delayed year old son of mildly retarded parents. His program consists primarily of daily special education classes and consultant therapy services. His family's program emphasizes meetings with a classroom teacher weekly at home or at the school. Parents also attend monthly all school parent education discussion sessions. Mr. and Mrs. B have been extremely cooperative and have made excellent progress. A teacher has worked with them in the home on such basics as how to arrange toys, how to play with their son, what is normal behaivor for a two year old, what are reasonable expectations, and effective behavior management techniques. Together they have gone through their toy box and chosen what is appropriate for his age. A great coup occured recently after little George had broken a prized piece of china; his mother noted that her instinct was to hit him, but instead she "timed herself out" and walked away. Both parents have asked staff for retorts to friends who urge them to spank their son. They are now able to reply that "for George that won't work, so we do it this way." The family, who used to refer to their child as "rat" or "monster," has begun to enjoy finding new positive pet names for George.

John was physically abused and entered the therapeutic day care program after hospitalization for hematoma and resulting hemiplegia. Fortunately he has no lingering disabilities as a result of his trauma, but he demonstrates a number of neurological "soft signs" and without intervention would likely become one of the many at-risk infants and toddlers who later develop school problems. He has been assessed by physical and speech therapists and spends two hours daily in the special education preschool classroom (with consultant therapy services) where he now functions as one of two nonhandicapped models. His father, primarily responsible for the abuse, has left the family. However his mother is extremely neglectful and the situation requires constant supervision. Mrs. C. brings John to the program but has done little else to comply with Child Protective Services or Merrywood suggestions. School staff are carefully feeling their way to insure maximum care and protection for the child while interfering as little as possible with the family's very fragile bonding/attachment process. We are endeavoring to gain Mrs. C's trust, but at this stage she cancels or is not home for home visits by staff and spends as little time at school as possible. We are keeping in mind Crittenden's observation (1983) of a paradoxical effect of mandatory daycare. Rather than offering respite to overly stressed families, the separation involved in day care can interfere with an already tenuous attachment process made problematic by earlier separation experiences such as foster care. To avoid exacerbating family rejection, agencies must treat the family unit, not merely the child, and work to gain the trust of families and involve them in their child's program.

Maxine Siegel is the executive director of the Merrywood School (Developmental and Neuromuscular Center) in Bellevue, Washington.

The author thanks the personnel of Merrywood School, including Sue White and Margaret Roberts, Childcare Coordinators, Carol Kyomizu, Social Worker, and Gerry Chatterton, Early Childhood Special Educator, who provided invaluable support for this project.

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Point of View:

Investing in Young Children

by Irving B. Harris

Note: *Mr. Harris is Chairman of the Executive Committee and Director of the Pittway Corporation and President of the Ounce of Prevention Fund. The following comments are excerpted from Mr. Harris' address to the National Governors' Association Committee on Human Resources Conference on "Focus on the First 60 Months," February 6, 1986. Copies of the address are available from the Ounce of Prevention Fund, 188 West Randolph, Suite 2200, Chicago, IL 60601.*

Every fall teachers in the Chicago school system see a new crop of children who are *not ready* for school. Talk to any inner-city kindergarten teacher and ask her: "If in the fall you have a child who is 'not ready,' who has an inadequate attention span, is hyperactive, or has speech or hearing problems, for example, how do you handle it?" The teachers I spoke to said: "If I have one child in my class who is 'not ready,' I am skilled enough so I can handle that child and at the same time handle the rest of the class." My next question was: "What would happen if you had two or three such children in your class?" The answer was that *there is no way for any teacher, no matter how skilled, to handle three children in a class of 30 who are 'not ready' without shortchanging the rest of the class.* I then asked: "Out of the 30 students in your class in September, how many of them in fact were 'not ready'?" The answer was given to me by four different teachers. The lowest estimate was 6, the highest 15. *All four teachers said that they know they are shortchanging all of the children in the class* because such a large percentage of the children they are trying to teach are "not ready." And they acknowledge that every year after kindergarten *all* students in these classes are being shortchanged, except in the few "magnet" schools.

Almost all of the $240 billion we annually invest in education is devoted to teaching children age 6 and older.

Almost all of the money we as a nation currently invest in education—$240 billion annually—is devoted to teaching children age six and older. Not much more than $1 billion goes to prepare the child for school. For the most deprived children, even Head Start is too late.

As a nation, we have to think through our policy about such deprived children. We *could* have a policy of investing heavily in preparing these children to succeed in today's America. Or, we can continue our existing policy which pays lip service to "preschool education," defined as three to five years of age, but ignores modern knowledge about early learning.

Private/public partnerships can be a particularly useful way of supporting innovative approaches to investment in our youngest children, approaches based on the best research on infant and family development. Family Focus and the Ounce of Prevention are good examples of what I mean.

Subjects and Predicates

In 1976, I helped to fund Family Focus, a project conceived by Bernice Weissbourd, who, after the experience of running an inner-city Head Start program, was distressed by the program's failure to reach the one-third of the children who were most at risk. She felt strongly that in order to prevent poor child development, she had to get to these children much earlier—which meant working with the families from the time the children were born.

Family Focus set up its first family support program in the fall of 1976 in Evanston, a suburb of Chicago. From the beginning, the program was very successful with white middle-class families. To attract the black teenage families, we started a second drop-in center three years later. Located close to Evanston Township High School, this program now includes an infant day care center and programs aimed at middle and high school teens.

Funding for Family Focus was difficult. Foundation grants usually terminated after three years, just as the need for funds was increasing. The possibility of corporate funding was carefully considered. It was thought that a center developed near a factory site,

where a corporation's self-interest would warrant a substanital corporate investment, might create a replicable model. One very logical corporation to conduct such an experiment was the Pittway Corporation, of which I was Chairman of the Board. One of our plants is located in Aurora, Illinois, where we manufacture First Alert smoke detectors. Aurora has a large and poor pocket of Hispanic families. Many of Pittway's employees are Hispanic. Pittway was willing and eager to help this community, as well as its own interest, by supplying a substantial part of the funds needed to finance a Family Focus drop-in center in Aurora.

The attraction of matching funds was essential to the creation of the Ounce of Prevention experiment.

As our plans progressed, we asked the Illinois Department of Children and Family Services (DCFS) for $25,000 a year towards our estimated $100,000 budget. Greg Coler, then Director of DCFS, reacted by saying that it was high time that the agency provide significant funding for programs that would broadly test the concept of primary prevention.

He volunteered to commit $400,000, if Pittway would match it, to establish six experimental sites that would test the concept of prevention. The Pittway board agreed with alacrity to match the grant, and The Ounce of Prevention Fund was created.

It would have been difficult for Director Coler to establish a radical experiment such as The Ounce of Prevention Fund using State funds alone. He felt that if DCFS could leverage its $400,000 on a matching grant basis, he would probably have less difficulty in obtaining legislative approval for prevention funds in following years, since the confidence being expressed by the Pittway Corporation would undoubtedly have some influence. He asked for a $400,000 grant from Pittway for one year only. He promised that once under way, the project would be funded in its second and third years by the State at $800,000 a year. And, despite the fact that this was by far the largest grant the Pittway Corporation Charitable Foundation had even considered, the board believed it was worthwhile, particularly in view of the fact that we were leveraging our $400,000 with $400,000 from the State in the first year, with their providing an additional $800,000 annually for two more years. Furthermore, Pittway directors had a strong feeling that the long-term success of the corporation depends upon the economic and social health of the community, not only in Aurora but in all of the communities where Pittway operates a factory or offers its products for sale. Similarly, the board felt that the issues related to early childhood development are of concern to the nation as a whole; thus Pittway's effort might have national significance.

In retrospect, it is clear neither DCFS nor Pittway could have been induced to undertake this experiment if it hadn't been for the attraction of matching funds. In this sense, the creation of The Ounce of Prevention Fund was done with mirrors.

We are now in our fourth year, with assurance of continued funding. So far, both the State and Pittway are well satisfied with our joint experiment. The first six programs grew to 28 programs in years two and three, and starting July 1, 1985, we added 14 more programs.

When The Ounce of Prevention Fund established its first programs, the goal was to work with poor mothers who had very young babies. Our aim was to teach better parenting skills, which would result in better nurturing and development of the child and an eventual avoidance of the whole roster of problems incurred by high-risk children.

In the first 18 months, we tried to keep the young mother in school, which meant, among other things, encouraging her to wait before having another baby. We were aware of the fact that the poverty cycle usually starts all over again with those babies, particularly with second babies. However, practically speaking, we spent so much of our effort trying to work with the mothers, that little effort was expended working with the children. We originally budgeted about $1,000 a year per family, enough for the two-thirds of the families not at the highest risk. From the start, we recognized our programs would only marginally help the highest-risk families.

The next stage of our prevention efforts at the Ounce was to try to prevent the first birth. We looked around to find out what programs had been successful in preventing first births. The only successful program we could find was the comprehensive school-based medical clinic model. In June 1985, we enabled Provident Hospital to establish a clinic at DuSable High School in Chicago, where, in 1984, with *a student population of 1,000 boys and 1,000 girls, 300 babies were born to teen mothers.* In addition to family planning services, the clinic is meeting the tremendous need for comprehensive medical care within the high school population: 80% of the visits are medical. In addition, we hope that the clinics will improve the prenatal care for pregnant students and reduce the number of infants born at high risk. Most of all, we hope to radically reduce the recidivism. *While nationally one-third of teenage mothers will have a second baby within 24 months, the St. Paul school clinic on which ours is modeled has cut second pregnancies to 1.4% in 24 months.*

The final objective we are now beginning to address is the prevention of developmental delays. The Beethoven Project (named for the Beethoven Elementary School on Chicago's south side) targets all the children born in that area, many of whom are indeed at very high risk. We plan to work, from birth, with the whole kindergarten class of 1992.

Prevention has to be our emphasis. And preparing our poor children to succeed with their education is the only way that they will ever succeed.

National Center Notes:

by Eleanor S. Szanton

"When anything is growing, one former is worth a thousand reformers."
(Horace Mann, *School and Society*, 1900)

This statement undoubtedly rings as true to the readership of *Zero to Three* in 1986 as it did to Horace Mann's fellow educators eighty-six years ago. We are all committed to helping those whose lives are largely in formation.

However, Mann's sentence is a little jarring. It may imply that those who support the growth and development of infants are writing on blank slates. We know that infants come to their families with individual temperaments and constitutional capacities, while their families, also in "formation," bring significant personal, group and cultural histories to their current situation. The statement also slights "reformers." Many of us deal daily with infants, toddlers and their families who, in some way or other, have come to us in order to change or improve the conditions of their lives. They, and we, are in some sense "reformers," and are committed to the success of our work.

Mann's words have a comforting ring, however, for two reasons: They remind us how much "form" is contained in "reform"—how much our attempts to change the lives of young children and their families depend on capturing and working with the natural developmental processes in formation. Secondly, the 1900 statement sounds positive compared to the words currently in vogue for work with infants and families. "Prevention" and "early intervention" appear to emphasize what will go wrong with a child or family without help from us. Unfortunately, it has been easier to attract funds for "prevention" or "intervention" against present or future ills than for promotion of healthy growth.

Let us, then, commit ourselves to, and convince others of, an outlook which sees prevention and intervention together as a part of a single comprehensive continuum of supports for lives in formation and reformation.

• • • •

In June, **Sally Provence,** President of the National Center, and **Albert J. Solnit,** Co-Chairman of our Fellowship Committee, each received an award from the Governor of Connecticut, on the occasion of the Golden Anniversary of Title V, the legislation setting up the Maternal and Child Health program. The awards were for "outstanding contributions to the health of mothers and children and dedicated service to the citizens of Connecticut." We congratulate two individuals who have devoted a large share of their professional lives to helping their own state devise ever more comprehensive programs—programs which bring together the "formers" and the "reformers."

Publications:

Group Care for Young Children: Considerations for Child Care and Health Professionals, Public Policy Makers, and Parents—Nina Gunzenhauser and Bettye M. Caldwell, editors (Skillman, NJ: Johnson & Johnson Baby Products Company, 1986) $9.00.

This volume is the summary of Johnson & Johnson's Pediatric Round Table 12, which brought together child care experts Bettye Caldwell, Ellen Galinsky, Helen Blank, Rebecca Fewell, Margaret Wishart, Michael Yogman, Susanne Martinez, Elinor Guggenheimer, Dana Friedman, Sandra Scarr, Juanita Fleming, Alma Friedman, David Belais Friedman, Judith Palfrey, Susan Aronson and Marilyn Smith to discuss the constituencies for child care, obtaining support, and professional diversity in the field.

The chapter by Alma Friedman and the late David Belais Friedman on interdisciplinary involvement in child care delineates the expertise health professionals, mental health and social work professionals, child development and education professionals, community service professionals, administrators, and designers can bring to child care issues. The authors suggest ways in which child care providers can use such consultants effectively. Susan Aronson, M.D. points out the abundant opportunities for health promotion in child care. Noting that few valid studies of the incidence of health problems in child care exist, she suggests ways in which child care centers can target injury control, prevention and management of infectious diseases, and attention to the health needs of individual children as areas for staff training and activity.

Keeping Current in Child Care Research: An Annotated Bibliography—Carollee Howes (National Association for the Education of Young Children, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009, 1986) $22.50

Initially prepared for a summer institute sponsored by the Society for Research in Child Development in 1985, this bibliography was designed for researchers, policy advocates, and teachers and students of child development. The bibliography emphasizes child development outcomes rather than the social and economic functions of child care. Sections are included on attachment, social development, cognitive development, experiences in child care, child care as early intervention, specific indicators of quality, effects of overall quality, age of entry, child's total experience, length of day, the family and child care, and review articles and books. For each reference, sample descriptions, salient variables, measures and results are provided. Research reports were included if they had been published in peer-reviewed journals or books or, in some cases, presented at professional meetings. The majority of the research was conducted in the United States.

The bibliography is organized in a looseleaf binder, to be used as a working document.

Report on a National Study of Parental Leaves—the staff of Catlyst (New York: Catalyst, 1986) available from Catalyst, Dept. PLH, 250 Park Avenue South, New York, NY 10003 for $60 plus $2 shipping and handling (discounts available for nonprofit organizations).

Work and Family Life in the United States: A Policy Initiative—a report of the Family Policy Panel of the Economic Policy Council of the United Nations Association of the USA, (New York: UNA-USA, 1985) Available from UNA-USA, 300 East 42nd St., New York, NY 10017 for $10.

Work and Family: A Changing Dynamic—a BNA special Report (Washington, D.C.; Bureau of National Affairs, Inc., 1986) available from BNA's Customer Service Center, 9435 Key West Avenue, Rockville, MD 20850 for $40.

Child Care and Corporate Productivity—John P. Fernandez (Lexington, MA: D.C. Heath and Company, Lexington Books, 1986) $25.00.

A Lesser Life: The Myth of Women's Liberation in America—Sylvia Ann Hewlett (New York: William Morrow and Company, Inc., 1986) $17.95.

Women and Children Last: The Plight of Poor Women in Affluent America—Ruth Sidel (New York: Viking Penquin Inc., 1986) $16.95.

Women constitute 45 percent of the American labor force. Ninety percent of women have children. Forty-eight percent of mothers with infants under one year of age are in the labor force. One-fourth of American children under six live in poverty. Single-parent families account for 26 percent of all families with children under 18. One out of every 4 women earned less than $10,000 working full time in 1984. Two-thirds of employees in a five-company study agreed that child care problems contribute to unproductive use of employees' minds and time. More than half of corporate respondents in a study of parental leave had changed their policies in the last five years.

Statistics such as these provide the starting point for the six publications listed above. Each publication, as their titles suggest, also has a particular perspective from which to view work and family issues in contemporary America and their impact on young children. Statistics are supplemented by case material, ranging from autobiographical material to interviews with individuals to examples of corporate and institutional programs. Four of the publications describe work/family policies and programs in other countries, with Sweden receiving particular attention. All of the publications contain family policy recommendations by the authors or report the recommendations of others. These include job-protected parental leave, with or without income replacement; public and corporate support for affordable, high quality child care; pay equity for women; financial support for children; improved and extended maternal and child health care services; and flexibility in the workplace regarding schedules, benefits, and career paths.

Toddler Day Care: A Guide to Responsive Caregiving—Robin Lynn Leavitt and Brenda Krause Eheart (Lexington, MA: D.C. Heath and Company, Lexington Books, 1985) $9.95.

For the past six years, the two authors of this book have directed the Infant-Toddler Center which is part of the Developmental Child Care Program at the University of Illinois, Urbana-Champaign. There they have focused on applying child development research and theory to day care settings in order to help student day care workers become responsive child development specialists.

Leavitt and Eheart voice concern about the trend in this country to overvalue the importance of "accomplisment" for young children, leading to toddler programs that seem "teacher-dominated, with a focus on early academics and arbitrary routines." At the same time, they see the importance of training for caregivers as undervalued. The authors stress, in contrast, the importance of applying research and theory to group care and of following the toddler's lead, creating a child-centered environment responsive to developmental and individual needs. These themes are elaborated in chapters on toddler play and how to support it; planning physical environments; managing routines in an individualized way; guiding behavior; assessing development; collaborating with parents; maintaining health and safety; and addressing professional issues.

Child Care Action Campaign Media Kit—Available from the Child Care Action Campaign, 99 Hudson Street, Room 1233, New York, NY 10013 for $3.00.

The Child Care Action Campaign, a non-profit corporation concerned with publicizing the need for child care and information about child care, has developed a two-part media kit. One section includes information on developing mailing lists, planning news conferences and special events, and preparing for interviews. The second, substantive, section includes statistics on child care in the United States, 30 common questions and answers about child care, and sample releases and letters to the media.

Advances in Infancy Research, Volume IV—Lewis Lipsitt and Carolyn Rovee-Collier, editors (Norwood, NJ: Ablex Publishing Corporation, 1986) $39.95.

The five chapters in this volume include "Infancy in the Sheep" by Margaret Vince and Anne Billing; "Child Development and Family Change: The Influences of Maternal Employment in Infants and Toddlers" by Jacqueline Lerner and Nancy Galambos; "Early Precursors of Later Depression: An Organizational Perspective" by Dante Cicchetti and J. Lawrence Aber; "The Rise and Fall of Infant Classical Conditioning Research" by Carolyn Rovee-Collier and a symposium on "Cross-Modal Functioning in Infancy."

In their discussion of the influences of maternal employment on infants and toddlers Lerner and Galambos use a contextually oriented life span developmental perspective to organize, examine and critique the literature on the subject. The authors' review of research suggests that the effects of maternal employment vary with child, contextual, and maternal variables, and that researchers are becoming increasingly sensitive to the variables (such as father's role, the social support systems available, gender differences in parent-child interaction, and features of the work situation) that contribute to the influences of maternal employment on the child. The authors also present a "process" model for investigating how maternal role satisfaction, as a mediating variable more important than the mother's employment status, but often linked to it, influences parent-child interaction and how parent-infant interaction, in turn, influences child development. Data from the New York Longitudinal Study are offered to support the notion that mother-child relationships have a stronger influence on child development than maternal employment per se.

Cicchetti and Aber review research on infants and toddlers of affectively ill parents from the Rochester Longitudianl Study and the NIMH/Colorado Collaborative Studies, which suggests that children may be more vulnerable to the insult of parental depression during their second and third years of life than during the first year. They go on to describe a transactional model for understanding how early risk factors for later depression may or may not eventuate in the disease.

New In Paperback

The following books, previously described in *Zero to Three*, are now available in paperback editions:

Children with Handicaps: A Medical Primer, Second Edition—Mark Batshaw and Yvonne Perret (Paul H. Brookes Publishing Company, P.O. Box 10624, Baltimore, MD 21285, 1986) $24.95.

First Feelings: Milestones in the Emotional Development of Your Baby and Child—Stanley Greenspan and Nancy Thorndike Greenspan (Viking Penguin, Inc., 40 West 23rd Street, New York, NY 10010, 1986) $3.95.

To Listen to a Child: Understanding the Normal Problems of Growing Up—T. Berry Brazelton (Addison—Wesley Publishing Company, Reading, MA 01867, 1984) $8.95.

For Your Information

The Office for Human Development Services in the Department of Health and Human Services has listed its priorities for its FY 1987 Coordinated Discretionary Funds Program. General priority areas include family support and community based care. Specific topics include assisting teenage parents in preventing child abuse and neglect, adoption of special needs children, parent support services to adoptive parents, parenting education for incarcerated parents, neglect of children, mental health services and the child welfare system, and prevention of abuse and neglect in infants of chemically dependent mothers. Application kits and information are available from the Department of HHS, HDS, Division of Research and Demonstration, 200 Independence Avenue, S.W., Room 724-F, Washington, D.C. 20201, tel: (202) 755-4366.

The National Institute of Mental Health has modified its system of grant awards to new researchers so that support can be made available for up to five years, with as much as $100,000 provided in some years (although total awards may not exceed $350,000). This step is designed to make intervention research projects more feasible. For information about the NIMH "FIRST" program, contact Victoria Levin, Center for Prevention Research, NIMH, Parklawn Building Room 11C-06, 5600 Fishers Lane, Rockville, MD 20857, tel: (301) 443-4283.

The National Institute of Mental Health is sponsoring a three-year multidisciplinary postdoctoral training program in research in family processes and psychopathology at ten sites. Fellows must spend time at a minimum of two sites during the three years. The program will begin in August, 1987 with an application deadline of January 7, 1987. For information write to E. Mavis Hetherington, Ph.D., Department of Psychology, Gilmer Hall, Admissions, Multisite Family Postdoctoral Program, University of Virginia, Charlottesville, VA 22903-2477.

Conference Call:

October, 1986

October 19-21: *The Michigan Association Concerned With School Age Parents* and the *National Organization on Adolescent Pregnancy and Parenting* will sponsor a meeting on "Adolescent Parents: Breaking the Cycle" in Flint, Michigan. Keynote speakers are Carol Cassell and Eloise Whitten. Contact the University of Michigan Extension Service, Department of Conferences and Institutes, 200 Hill Street, Ann Arbor, MI 48104, tel: (313) 764-5304.

October 24-26: *The National Down Syndrome Congress* will hold its 14th annual convention in Wichita, Kansas. Among other presenters, Diane Alexander will speak on federal research initiatives and Diane Bricker will discuss a systems approach to early intervention. Contact National Down Syndrome Congress, 1800 Dempster Street, Park Ridge, 60068-1146, tel: 1-800-232-NDSC.

October 27: *The Coalition of Infant Toddler Educators* and the *Department of Early Childhood and Family Life Education* will present a conference on "Training Personnel in Infant/Toddler Centers and Homes" at Kean College, Union, New Jersey. Write or call A. Restaino-Kelly, 246 Flanders-Netcong Road, Flanders, NJ 07836, tel: (201) 927-9301.

Continued on back cover

1. Vulnerable Infants, Stressed Families: Challenges for Research and Practice

A regional training institute

February 20-22, 1987
Westin Bonaventure Hotel
Los Angeles, California

Sponsors: California First Chance Consortium; California Infant Development Association; California March of Dimes; California State Department of Developmental Services; California State Department of Education (Child Development Division and Infant-Pre-school Unit of the Special Education Division); California State Department of Health Services, Maternal and Child Health Branch; California State Department of Mental Health; Infant Pre-School Special Education Resource Network (SERN), Interact, the National Committee for Special Needs Infants and Their Families; and the National Center for Clinical Infant Programs (Project Zero to Three, Grant #113271, Division of Maternal and Child Health, U.S. Department of Health and Human Services).

The institute will bring together a nationally known, multidisciplinary faculty and practitioners, researchers, systems planners and administrators from California and other western states who are concerned with infants, toddlers and their families.

Four areas will receive special attention at the institute:

1) the needs of infants and toddlers in child care, their families and their care providers;
2) multicultural issues in serving young children and families;
3) supporting the development of high-risk and developmentally disabled infants, toddlers and their families;
4) issues concerning the infants and toddlers of substance-abusing parents.

These concerns will be addressed in specialized pre-institute seminars, plenary addresses, case presentations, invited special interest presentations, and panels and posters selected from a call for papers. Additional plenary addresses will focus on the interaction among research findings, ethical values, clinical practice and public policy affecting young children and families.

INSTITUTE PROGRAM

Friday, February 20: 9-11:30 a.m.
PRE-INSTITUTE SEMINARS—*limited registration*

A. Concepts in infant mental health
Stanley I. Greenspan, M.D.—Infant and Child Clinical Development Services Program, Division of Maternal and Child Health, HRSA, DHHS
Stephen Seligman, D.M.H.—San Francisco General Hospital, University of California, San Francisco

B. Concepts in developmental disability in the first three years of life
James Blackman, M.D.—University of Iowa
Marci Hanson, Ph.D.—San Francisco State University

C. Issues in providing child care for at-risk or disabled infants and toddlers
Maureen Ballard-Campbell, Ph.D.—California State University, Sacramento
Michael Ballard-Campbell, Ph.D—California State University, Sacramento

D. Interagency plans for disabled and at-risk infants and toddlers
Phyllis Magrab, Ph.D.—National Center for Networking and Community Based Services, Georgetown University, Washington, D.C.
Linda Brekken—Infant Pre School Project, Special Education Resource Network, Sacramento, California
Mary Elder—Early Childhood Intervention, Austin, Texas
Andrea Weiss—Early Childhood Developmental Services Unit, Massachusetts Department of Public Health

E. Warning signals: how non-medical service providers can identify and serve infants and toddlers at risk for developmental problems
Annette Tessier, Ed.D.—CSULA, Department of Special Education
Diane Klein, Ph.D.—CSULA, Department of Speech

F. Assessing infant and toddler development through play
Rebecca Fewell, Ph.D.—University of Washington

G. Understanding behavioral cues of preterm infants
Peter Gorski, M.D.—Evanston Hospital, Evanston, Illinois, (invited),
Kathy Vandenberg, M.A.—Oakland Children's Hospital

H. Integrating mental health perspectives into work with disabled infants, toddlers and their families
Rune Simeonsson, Ph.D.—University of North Carolina

I. Program evaluation: issues and strategies for service providers
Anneliese Korner, Ph.D.—Stanford University School of Medicine
Jeree Pawl, Ph.D.—San Francisco General Hospital, University of California, San Francisco
Victoria Seitz, Ph.D.—Yale University, New Haven, Connecticut

J. Caring for infants and toddlers with respect
Magda Gerber, M.A.—Resources for Infant Educarers, Los Angeles, California

K. Cultural issues in infant and toddler child care
Carol Phillips, Ph.D.—Council for Early Childhood Professional Recognition, Washington, D.C.
Nicola Trumbo, M.A., M.F.C.C.—Branch Consultants, Pasadena, California

L. Second language acquisition for infants and toddlers
Mary McGroarty, Ph.D.—Department of Linguistics, UCLA
Concepcion Valadez, Ph.D.—UCLA School of Education

Friday afternoon, February 20
PLENARY SESSION

Welcome
Arthur H. Parmelee, M.D.—University of California Medical Center, Los Angeles

Vulnerable infants, stressed families: the implications of epidemiological and clinical research findings for policy and practice
C. Arden, Miller, M.D.—Department of Maternal and Child Health, School of Public Health, University of North Carolina
Stanley I. Greenspan, M.D.—Infant and Child Clinical Development Services Program, Division of Maternal and Child Health, HRSA, DHHS
Discussant: *Asa G. Hilliard, III*—Georgia State University, Atlanta

SIMULTANEOUS CASE PRESENTATIONS

1. Parent, infant and caregiver: working team or troubled triangle?
J. Ronald Lally, Ed.D.—Far West Laboratory for Educational Research and Development, San Francisco, California

2. Perinatal addiction and developmental consequences: working with infants and families
Vickie Kropenske, PHN, R.N.—UCLA Intervention Program
Judy Howard, M.D.—UCLA Intervention Program

3. Working with an Hispanic infant and family
Alicia Lieberman, Ph.D.—San Francisco General Hospital, University of California, San Francisco

4. Working with an Asian infant and family
Sam Chen, Ph.D.—University Affiliated Program, Los Angeles Children's Hospital, Los Angeles, California

5. A disabled infant and his family
Lisbeth Vincent, Ph.D.—University of Wisconsin

6. A chronically ill infant and family
Monica Jones—Santa Barbara, California
Diane Filley—San Diego, California

7. Meeting the needs of premature infants in the community
Sharlyn Hansen, R.N, M.R.N.—California State Department of Developmental Services

Reception and poster session

Saturday, February 21

PLENARY SESSION

Caring for infants and toddlers in a changing society: the impact of research, values and policy on practice
Sally Provence, M.D.—Yale University School of Medicine, New Haven, Connecticut
Bernice Weissbourd, M.A.—Family Focus, Evanston, Illinois
Discussant: *Janet Poole, Ph.D.*—Child Development Division, California State Department of Education

Special interest sessions related to infants and toddlers in child care; multicultural issues; disabled and at-risk infants and toddlers; and young children of substance-abusing parents. Invited presentations.

Luncheon—Optional, additional fee
Panel (for all participants)

Working with infants, toddlers and their families: What we do and how we keep going
Kathryn Barnard, Ph.D., R.N.—University of Washington
Geneva Woodruff, Ph.D.—Project PACT, Brighton, Massachusetts
Jeree Pawl, Ph.D.—San Francisco General Hospital, University of California, San Francisco
Sally Provence, M.D.—Yale University School of Medicine, New Haven, Connecticut

PLENARY SESSION

Caring for disabled and medically at-risk newborns, infants and toddlers: the impact of research, values and policy on practice.
Alan Fleischman, M.D.—Albert Einstein College of Medicine and Montefiore Medical Center, Bronx, New York
Diane Bricker, Ph.D.—University of Oregon

Discussant: *Marilu Hickman, M.D.*—California Department of Developmental Services

Panel presentations, selected from a call for proposals, addressing four target areas of concern

Sunday, February 22

Special interest sessions (see Saturday morning)

PLENARY SESSIONS

Infants in multirisk families: research, service and policy perspectives
Dante Cicchetti, Ph.D.—University of Rochester, Rochester, New York
Arnold Sameroff, Ph.D.—Brown University, Providence, Rhode Island
Discussant: *Sam Chen, Ph.D.*—Los Angeles Children's Hospital, Los Angeles, California

CONCLUDING PLENARY SESSION

Vulnerable infants, stressed families: new directions for practice and policy
Merle McPherson, M.D.—Division of Maternal and Child Health, U.S. Department of Health and Human Services
Edward Zigler, Ph.D.—Yale University, New Haven, Connecticut
Hon. George Miller—U.S. House of Representatives

REGISTRATION INFORMATION

Registration is limited. The registration fee of $75 will cover admission to all institute sessions.

An additional fee of $25 will be charged for *pre-institute* seminars on Friday morning, February 20. Registration is limited and will be made on a first come, first served basis. Please indicate first and second choices. Pre-institute seminar participants must register for the entire training institute.

A fee of $15.00 will be charged for the luncheon on Saturday, February 21. (Participants not attending the luncheon will be able to join the group to hear post-luncheon speakers). The reception on Friday evening, February 20 will include a cash bar.

Any cancellation must be made in writing accompanied by a self-addressed stamped envelope. For cancellations received after January 30, $15 will be deducted from the refund. No refunds will be made for cancellations after February 13.

Accommodations

Accommodations are available at the Westin Bonaventure Hotel, Los Angeles at conference rates of $75 single, $85 double, and $100 triple (not including tax). Call toll-free, 1-800-228-3000 before January 20.

Continuing education credits

Continuing education credits for physicians and nurses will be available.

AN INVITATION TO A NEW TRAINING EXPERIENCE

2. Building Excellence in Comprehensive Services to Infants, Toddlers and Their Families:

Strategies for Practitioners, Supervisors, Educators and Administrators

A 4-day intensive course

March 9-12, 1987
The New School for Social Research
New York, New York

Sponsors: The National Center for Clinical Infant Programs, with support from the Division of Maternal and Child Health, U.S. Department of Health and Human Services, Grant #113271 and Schneider Children's Hospital of Long Island Jewish Medical Center, in collaboration with the Center for Infants and Parents, Columbia University; the New School for Social Research; Bank Street College of Education; and the New Jersey State Interdepartmental 0-3 Committee.

"Building Excellence" represents a new approach to training for the National Center for Clinical Infant Programs. This intensive course will offer 25-50 selected participants the opportunity:

- to acquire and integrate new information about emotional social, cognitive and physical development in the first three years of life;
- to become familiar with specific strategies for screening; assessment; diagnosis; planning and implementing intervention; staff training; interagency coordination, and program evaluation, as they relate to health, mental health and educational services for normal, disabled and at risk infants, toddlers and their families;
- to interact in an intimate seminar setting with colleagues facing similar professional challenges; with professionals from other disciplines and settings; and with nationally recognized faculty;
- to apply new concepts through case discussion and problem solving.

Participants

Individuals are encouraged to apply who are:

- supervisors, training directors and faculty responsible for staff development, professional education, and in-service training of experienced staff, new staff, paraprofessionals and volunteers;
- administrators and systems planners responsible for planning, implementing, monitoring, evaluating and coordinating existing or future services for normal, disabled and at-risk infants, toddlers and their families;
- practitioners, from a range of professional disciplines, already working with children from birth to three and their families;
- individuals about to assume new positions in one of the categories listed above.

Tuition

Tuition for the 4-day course is $450 and includes all materials and transportation from the course location to site visits. Partial scholarships may be available for tuition and for travel and living expenses.

Course content and faculty

Stanley Greenspan, M.D., Chief of the Infant and Child Development Services Program, Division of Maternal and Child Health, U.S. Department of Health and Human Services, will present for a total of 8 hours to all participants on Monday, March 9 and Tuesday, March 10. The first day will focus on normal and atypical development from birth to three, with attention to issues of screening, assessment and differential diagnosis. The seond day will examine comprehensive approaches to planning and implementing intervention, as exemplified by the work of the individual practitioner, the team and the service system. Discussion will include ways to integrate mental health, special education, OT/PT and other approaches to work with various types of infants, toddlers and their families.

Small study groups applying the concepts introduced by Dr. Greenspan to the specialized work of practitioners, supervisors, educators and administrators, and addressing additional issues of particular concern to these groups, will be led on March 9 and 10 by: **Joanna Erikson**, Health Services for Handicapped Children, Connecticut Department of Health Services; **Barbara Fields, M.A., M.S.W.,** Larchmont, New York; **Delia Gorga, Ph.D.** Department of Rehbilitation Medicine, New York Hospital-Cornell Medical Center; **Daniel Kessler, M.D.,**New York Hopital—Cornell Medical Center; and **Lorraine McCune, Ph.D.,** Infant Specialist Program, Rutgers University Graduate School of Education. These faculty members will be available throughout the course, and will be joined for specific discussions by **Sally Provence, M.D.,** Yale University School of Medicine, and other members of the planning committee.

Guided site visits to infant and toddler research and service programs in hospital, community and university settings in New York and New Jersey will take place on Wednesday, March 11.

On Thursday, March 12, **Kyle Pruett, M.D.** and colleagues from the Yale Child Study Center will present and discuss a case that illustrates how several disciplines and levels of personnel work with an infant and family. Participants will then meet in small study groups with continuing course faculty to discuss, in light of the week's learning, issues raised by case material distributed prior to the course.

Opportunities for informal discussion and socializing among participants and faculty will be provided through out the 4-day course.

The regional conference scheduled for March 13-14 is planned to intersect with and extend the intensive training. It will allow course participants to join a larger faculty and attendees from the mid-Atlantic region in examining ways of mobilizing the resources essential to create and maintain high quality services for normal, disabled and at risk infants, toddlers and their families. (See description following of "People, Skills and Money" conference). Since special interest seminars at the regional conference will be designed to meet the needs of specific audiences, course participants will be able to select seminars that complement the work of the 4-day course.

Materials

All participants will receive background and study materials prior to the course and additional materials designed for agency distribution and/or for use with trainees.

Applications

Requests for applications must be received no later than **November 10, 1986.** Completed applications must be received no later than **December 1, 1986.** Notification of acceptance and scholarship awards will be made by **December 31, 1986.**

Course sponsors will work to select a group of participants whose disciplines, job responsibilities, interests and experience are such that the course can address their individual needs as well as the concerns of the group as a whole. The course will be given *only if* the co-sponsors and planning committee are satisfied that such a group can be selected from the pool of applicants.

3. People, Skills and Money: Building Comprehensive Community Services for Infants, Toddlers and Their Families

A regional conference

March 13-14, 1987
Garden City Hotel
Garden City, Long Island, New York

Sponsors: Schneider Children's Hospital of the Long Island Jewish Medical Center and the National Center for Clinical Infant Programs (Project Zero to Three, Grant #113271, Division of Maternal and Child Health, U.S. Department of Health and Human Services).

The purpose of this two-day conference is to bring together practitioners from many disciplines, parents, administrators, and researchers to examine ways of mobilizing the resources essential to creating and maintaining high quality services for normal, disabled and at-risk infants, toddlers and their families. Such resources include a knowledge base continually expanded by new research; pre-service and in-service training to translate knowledge into practice; effective collaboration between professionals from different disciplines, and between agencies; meaningful partnerships between parents and professionals; and funding that is both adequate and appropriately allocated.

Pleanary and special interest sessions have been designed to address the needs of both individuals with considerable experience in working with infants and their families and of those beginning a specialization in this area.

Friday, March 13

REGISTRATION AND COFFEE

OPENING PLENARY SESSION

Helping Young Children and Families Get What They Need
Edward Zigler, Ph.D.—Yale University, New Haven, Connecticut
Vince Hutchins, M.D.—Director, Division Maternal and Child Health, DHHS

Simultaneous case presentations—pre-registration necessary to assure choice of session

A. Multidisciplinary perspectives on two premature infants: a follow-up over 3½ years
Philip Lipsitz, M.D., Elsa Blum, Ph.D., Eileen Dowd, M.S., and *Donna Morrison, M.S.*—Schneider Children's Hospital, Long Island Jewish Medical Center

B. Hospital/home/community treatment for a technology dependent infant
Mary Donner, Children's Hospital, Philadelphia
Martha Needleman, R.N., B.S.N.—New Jersey Special Child Health Services

C. Beginning intervention with a two-year old and his mother: limitations and opportunities
Andronike Tsamas, L.C.S.W.—Spence-Chapin Children's House, New York City

D. Against enormous odds: the struggle for clinical adequacy in a 0-3 mental health day care setting
Christina Sekaer, M.D.—St. Luke's-Roosevelt Hospital, New York City
Phyllis Sloate, Ph.D.—Columbia University, New York City

E. Issues of mother-daughter interaction during the separation-individuation process
Anni Bergman, Ph.D.—CUNY Psychological Center, New York City

F. When brief mother-infant psychotherapy may be too brief: treatment and 3-year follow-up
Nathan Szajnberg, M.D.—Child Psychiatry Programs, The University of Connecticut Health Center

Luncheon with faculty or on your own. A group meal will be available at an additional cost of $25. Participants may register in advance to be seated with the case presenter whose session they attended.

Simultaneous special interest seminars—participants will be able to choose on-site. Seminars marked with a * are likely to be of interest to beginning practitioners; those with †, to advanced clinicians; those with a #, to administrators and planners.

1. Precursors of language; developmental implications for the disabled infant
Selma Marcovici, M.S.—Schneider Children's Hospital,†

2. Motor dysfunction: risk factors, diagnosis and intervention
Angeles Badell, M.D., Andrew Steele, M.D., Lydia Eviatar—Schneider Children's Hospital, *#

3. Models for assuring quality early intervention services for disabled and at-risk infants and toddlers
Andrea Weiss, M.A.—Massachusetts Department of Public Health
Mary Fleck, M.N.Ed.—New Jersey Department of Education, #

4. Program evaluation: issues and strategies for service providers and administrators
Sally Provence, M.D.—Yale University School of Medicine
Eleanor Szanton, Ph.D.—National Center for Clinical Infant Programs, *†#

5. Information and referral: linking families and professionals
Patricia Hill, Ed.D.—UMDNJ-Rutgers Medical School
Micahel C. Plotzker—New York State Education Department
Gloria Wallick—Day Care Council of Nassau County *†#

6. Bioethical considerations in the care of handicapped newborns, in pediatric treatment and in research
Philip Lanzkowsky, M.D., Andrew Adesman, M.D. and *Paul Lipkin, M.D.*—Schneider Children's Hospital *†#

7. Early intervention in the inner city: are the odds insurmountable?
Thea Bry—UMDNJ Newark
Steven Bennett, M.D.—Harlem Hospital, New York City *†#

8. Parent-professional partnerships
Judith S. Bloch—ACSW, Variety Pre-Schooler's Workshop, Long Island, New York, *#

9. Tracking and outreach: strategies for follow-up care of high risk infants
Symme Trachtenberg—Children's Hospital, Philadelphia
Peggy Patton, R.N.—New York State Department of Health, *†#

10. Failure to thrive—Whose failure? Infant, parent or professional?
Daniel Kessler, M.D.—New York Hospital-Cornell Medical Center, †

11. Involving corporations in support for working families
Suasn Ginsberg—Bank Street College of Education, *†#

Poster session selected from call for papers, reception, and sharing concerns among regional groups.

Evening, showcase for videos on infancy

Saturday, March 14
Showcase for videos on infancy

PLENARY SESSION

Neurodevelopmental and emotional growth in infancy: conceptual frameworks for integrated practice
Gordon Williamson, Ph.D.—John F. Kennedy Center, Edison, New Jersey
Michael Lewis, Ph.D.—UMDNJ-Robert Wood Johnson Medical School
Sally Provence, M.D.—Yale University School of Medicine

Simultaneous special interest presentations and panels chosen from a call for papers—for submission guidelines, contact conference coordinator. Deadline: November 15, 1986

Luncheon—group meal or on your own
Luncheon address—What European infants and families have that Americans haven't got (yet)
Alfred Kahn, D.S.W.—Columbia University School of Social Work
The luncheon address will be open to all participants.

SIMULTANEOUS PANELS

A. Funding research and services for infants, toddlers and their families
Vince Hutchins, M.D.—Director, Division of Maternal and Child Health, DHHS, Chair
Kathryn Rowan—New Jersey Developmental Disabilities Council
Jane Dustan—Foundation for Child Development

B. Infants, toddlers and the legal system: survival tips for the clinician
Stephen Herman, M.D.—New York Hospital-Cornell Medical Center

C. Training for a career in infancy
Nancy Balaban, Ed.D.—Bank Street College of Education, New York City, Chair
Patricia Nachman, Ph.D.—Margaret S. Mahler Observational Research Nursery, New York City
Irene Hassett, Ph.D.—Schneider Children's Hospital
Annett Axtmann, Ed.D.—Columbia University Teacher's College, New York City

Continuing education credits

Credits will be available for physicians, psychologists and social workers.

Accommodations

Conference rates for single, double and triple rooms will be offered by the Garden City Hotel, New York.

Registration information

Registration is limited. The registration fee of $75 will cover admission to all institute sessions.

A fee of $25 each will be charged for luncheons on Friday, March 13 and Saturday, March 14. (Participants not attending the luncheon will be able to join the group to hear the post-luncheon speaker on March 14). The reception on Friday, March 13 will include a cash bar.

Any cancellation must be made in writing accompanied by a self-addressed stamped envelope. For cancellations received after February 27, $15 will be deducted from the refund. No refunds will be made for cancellations after March 6.

1. REGISTRATION

☐ I wish to register for "Vulnerable Infants, Stressed Families," February 20-22, 1987 ($75) $ ____

☐ Please enroll me in the 2-1/2 hour pre-institute seminar indicated below (Give first, second and third choice) ($25) $ ____

- ☐ **A.** Concepts in infant mental health
- ☐ **B.** Concepts in developmental disability
- ☐ **C.** Child care for disabled/at-risk infants
- ☐ **D.** Interagency plans for disabled/at-risk infants and toddlers
- ☐ **E.** Warning signals: identifying infants at risk
- ☐ **F.** Assessing infant/toddler development through play
- ☐ **G.** Behavioral cues of preterm infants
- ☐ **H.** Mental health perspectives in work with disabled infants and their families
- ☐ **I.** Program evaluation for service providers
- ☐ **J.** Caring for infants with respect
- ☐ **K.** Cultural issues in infant/toddler child care
- ☐ **L.** Second laguage acquisition for infants and toddlers

☐ I wish to attend the luncheon on Saturday, February 21, ($15) $ ____

Total amount enclosed $ ____
(Make checks payable to Infant Conference '87)

Name ____________________

Address ____________________

City ____________ State ______ Zip ______

Phone: Home ____________ Office ____________

If you wish a confirmation of registration, confirmation of your assignment to a pre-institute seminar, and/or hotel information please enclose a self-addressed, stamped envelope with this form.

Return to:

Fran Chasen or Vivian Weinstein
Infant Conference '87
Exceptional Children's Foundation
2225 W. Adams Boulevard
Los Angeles, California 90018
(213) 735- 6132

2. APPLICATION

Please send me an application for admission to the course, "Building Excellence in Comprehensive Services to Infants, Toddlers and Their Families," March 9-12, 1987.

Name ____________________

Job Title ____________________

____

Address ____________________

City ____________ State ______ Zip ______

Phone: Home ____________ Office ____________

Return by November 10, 1986 to:

Emily Schrag
Building Excellence
NCCIP
733 15th Street, N.W., #912
Washington, D.C. 20005
(202) 347-0308

NOTICE: All registrants or applicants for training are requested to provide the information indicated below.

Professional discipline

- ___ Child development
- ___ Early childhood education and/or day care
- ___ Nursing
- ___ Occupational therapy
- ___ Parent and/or child advocacy
- ___ Pediatrics
- ___ Physical therapy
- ___ Psychiatry and/or psychoanalysis
- ___ Psychology-clinical
- ___ Psychology-developmental
- ___ Public health administration
- ___ Social work
- ___ Special education
- ___ Speech pathology
- ___ Other (please specify) ____________ ____________

Principal institutional affiliation

- ___ Hospital or hospital-based clinic
- ___ Education institution (nursery school, day care center, etc.)
- ___ University
- ___ Private practice
- ___ Social agency
- ___ Family support program
- ___ Community mental health center
- ___ Community health center
- ___ Federal government
- ___ State government
- ___ Regional government
- ___ Local government
- ___ Legislative body
- ___ Advocacy group
- ___ Other (Please specify) ____________ ____________

3. REGISTRATION

☐ I wish to register for "People, Skills and Money," March 13-14, 1987 ($75) $ ____

☐ Please enroll me for the following case presentation (give first and second choices)

- ☐ **A.** Multidisciplinary perspectives on two premature infants
- ☐ **B.** Hospital/home/community treatment for a technology dependent infant
- ☐ **C.** Beginning intervention with a two-year old and his mother
- ☐ **D.** Struggle for clinical adequacy in a 0-3 mental health day care setting
- ☐ **E.** Mother-daughter interaction during separation-individuation
- ☐ **F.** Brief mother-infant psychotherapy

☐ I wish to attend the luncheon on March 13 (participants will be seated with case presenters as long as space is available) ($25) $ ____

☐ I wish to attend the luncheon on March 14 ($25) $ ____

Total amount due $ ____

☐ Enclosed is a check, payable to Long Island Jewish Medical Center for $ __________

☐ Charge to ___ Master Card ___ Visa ___ American Express

Acct # ______________________________

Credit card expiration date ______________________

Signature ______________________________

I need hotel accommodations as follow:
___ single ___ double ___ triple

☐ I have made a reservation at the Garden City Hotel.
☐ I will contact the Garden City Hotel—(516) 747-3000.
☐ I have made other overnight arrangements.
☐ I would like to request a roommate (if available).

Name ______________________________

Address ______________________________

City ____________________ State ______ Zip ________

Phone: Home ________________ Office ________________

Please fill out discipline/affiliation form on opposite page.

If you wish confirmation of registration, of case presentation assignment, and of luncheon seating, please enclose a self-addressed stamped envelope with this form.

Return to: Ann Boehme
Continuing Education Coordinator
Long Island Jewish Medical Center
New Hyde Park, New York 11042
(718) 470-8650

Zero to Three

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733 15th St., N.W. Suite 912
Washington, D.C. 20005

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Mailing Address ______________________________

____

City ______________________________

State ____________________ Zip ________

Professional discipline ______________________________

____

Institutional affiliations (no more than 2) ________________

____

____

Continued from page 19

October 23-25: *Harvard Medical School, Department of Continuing Education* will hold a course on "Children and Society: Health Policy and Practice" in Boston, Massachusetts. The section on infancy will present current thought on causes of infant mortality and failure to thrive and will examine day care settings and their effects on children. Speakers include Robert Coles, Paul West, Jerome Kagan, Philip Toltzis, Donna Ambrosino, William Bithoney, Bernard Guyer, Eli Newberger, Deborah Klein Walker and Julius Richmond. Write or call Harvard Medical School, Department of Continuing Education, Boston, Ma 02115, tel: (617) 732-1525.

November, 1986

November 1-4: *The National Perinatal Association* will hold its annual conference in Washington, D.C. with the theme "New Perspectives and Action." Keynote speakers will be Alfred Kahn, David Blumenthal and Wilbur Cohen. Contact the National Perinatal Association, 101½ S. Union Street, Alexandria, VA 22314, tel: (703) 549-5523.

November 5-8: *The National Mental Health Association* will hold its annual meeting in Milwaukee, Wisconsin, focusing on the mental health of children and adolescents. Jane Knitzer, Bill Buzogany, Bruce Babbitt, Chris Ziegler, Colleen Bevis, Ira Lourie, Stephen Goldston, Preston Garrison and Charles Roppell will be speakers. Contact the Field Services Department, NMHA, 1021 Prince Street, Alexandria, VA 22314-2971, tel: (703) 684-7722.

November 13-15, 20-22: *Symposia Medicus* will sponsor a National Symposium of Perinatal Nursing in Chicago, Illinois November 13-15 and in Anaheim, California November 20-22. Each symposium has been designed individually with presentations addressing the care of mother, fetus and infant. Contact Symposium Medicus, 2815 Mitchell Drive, Suite 108, Walnut Creek, CA 94598, tel: (415) 735-7889.

November 13-16: *The National Association for the Education of Young Children* will hold its annual conference in Washington, D.C. Pre-conference sessions will include "Family resource programs: learning from experience, building a future," presented by Family Focus, Inc. and "Working with families as we care for their infants and toddlers," presented by Eleanor Szanton, Bernice Weissbourd, Alice Honig, J. Ronald Lally, and Serena Wieder. Tracks on infants/toddlers, child care, and families are also features of the conference. Contact NAEYC, 1834 Connecticut Avenue, N.W., Washington, D.C. 20009, tel: (800) 424-2460.

Zero to Three

National Center for Clinical Infant Programs
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Individual Differences in Infants

by
Lois Barclay Murphy
Menninger Foundation (retired)

Grace M. Heider
University of Kansas (retired)

Colleen T. Small
Fairfax County, Virginia Child Fund

Babies are infinitely individual. Unique footprints guarantee the identity of the baby in the hospital; brain waves and heart rate also show individualized patterns. Although all infants share common needs for nurturance and care, every infant has his or her own preferences, tastes, developmental style and potentialities.

It is ironic that devoted gardeners and animal lovers are much more aware of individual differences in their plants and in their cats, dogs, horses and birds than are some caregivers of children. A good gardener is not content with general information about what a plant needs at the seedling stage or at transplanting. He considers also how much sun, shade, moisture, space, and type of fertilizer a particular plant needs in order to develop optimally and to produce the finest blossoms or fruit of which it is capable. The pet owner accommodates to one cat who wants close contact, a rub against one's leg before its feeding, while respecting another cat who keeps its distance and shares no longing for intimacy. The animal lover recognizes that one dog is quick to respond to discipline while another is constantly challenging.

André and Jeremy, shown at 20 months, were born one week apart.

STERNBERG FAMILY ARCHIVE

Mother nature does not make xerox copies of people. We and other investigators have been observing the individual patterns of strengths and weaknesses in babies for fifty years, and are convinced that a descriptive, non-pejorative approach to every infant's strengths, weaknesses, vulnerabilities and capacities for resilience makes it possible to look a each child in a constructive, balanced way and to support a child's positive resources.

As we review the scientific investigation of individual differences in infants during the past half century, we will suggest the implications of new knowledge and theoretical constructs for the way we think about babies and, most importantly, for the way we raise them.

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Early studies of individual differences

Families have always seen differences in their babies, describing them as sturdy or fragile, difficult or easy, wide-eyed or sleepy, energetic or lazy feeders. Relatives have also been interested in any new baby's resemblance to members of the extended family —"she has her grandmother's kitty face." Child development researchers have varied in their approaches to infants, some concentrating on general principles of development and others attending more to individual differences.

During the first half of this century, studies of infants and children focused on specific traits, and specific events with their antecedents and consequences; conclusions were based on statistical correlations between potential contributing factors and items of behavior. We learned a great deal from this approach but at certain points it was misleading. For instance, studies of I.Q. in large groups of children over a period of years led to the conclusion that children's I.Q.'s were stable and that intelligence was inborn. Such studies ignored the fact that the children whose I.Q.'s increased balanced those whose I.Q.'s decreased. (Murphy and Moriarty, 1976, p. 384).

Half a century ago, most studies of infants focused on specific traits and based conclusions on statistical correlations. Reseachers made little effort to explore the effect of individual differences in infants on their relationships or on their emerging developmental styles.

In the 1920's, child development institutes were being established in this country with the support of Laura Spelman Rochefeller grants and the creative imagination of Lawrence K. Frank (1966). The emphasis in most of the research at this time was on developmental sequences seen in terms of averages — the *range* of individual differences at each step was not usually provided. Investigators sought general principles. But the development of tests for infant intelligence — and studies of the inheritance of maze-learning ability in rats — called attention to differences in motor skills in infancy. At first these were thought to be indicators of mental abilities which could only be assessed after the child had acquired language and a wider range of skills. (By the 1940's it became clear that there was little correlation between the performance of the baby and that of the teenager on mental tests [Bayley, 1949].)

In the 1930's, Skeels and Skodak (1938) documented positive changes in social responsiveness in reaction to a child's changed status and level of security in the group. Later Spitz (1943) discussed the influence of differences in previous experience on the level of infants' reactions to separation from the mother; he noted that "the best-mothered babies" became most depressed.

Mary Shirley (1933) at the University of Minnesota reported individual differences in babies she studied to the age of two years: she recorded not only average ages of appearance of developmental steps, but quartiles which documented differences in, for instance, the age of the first social smile. Mary Jones and Barbara Burks (1936) also found some babies smiling before the end of the first month. Ruth Washburn (1929) played typical

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baby-games designed to evoke laughter, and discovered that some babies did not laugh, while others laughed in some games and became sober (anxious?) or cried in others. In 1939, Mary Shirley reported that premature babies tended to be more sensitive in sensory areas, and to have less adequate coordination that full-term infants, but this report was not followed by studies of such differences in full-term babies with different prenatal experiences.

Jeremy enjoyed being cuddled at 4 days and continued to do so during the first two years of his life.

Half a century ago, then, important beginnings were made in the study of individual differences in infants. For the most part, however, researchers made little effort to explore the effect of these differences on the infant's relationships with family or the caregivers and on the emerging developmental style of the child. It was not until the 1950's that Katherine Wolf and Ernest Kries at the Yale Child Study Center and Sibylle Escalona at the Menninger Foundation concentrated on the comprehensive study of individual differences in babies. Of course families did not need to be told about differences in chubbiness or slenderness, in tendencies to sleep through the night or to wake often, to be a lazy feeder or a greedy one, as well as the difference between an irritable baby an a good-natured one. but Escalona and the Yale group studied a wide range of differences, including qualities of attentiveness, energy, and responsiveness to things and to people. While earlier investigators, focusing on typical or average patterns, talked about the concept of "8 month stranger anxiety," Escalona and Leitch and the Yale researchers reported on babies who were fearful of strangers at the age of three months and infants who seemed attached to their mothers at earlier ages than typically described.

In the same decade, Roger Williams (1956), a biochemist at the University of Texas, published an extraordinary book, *Biochemical Individuality*, with implications for every aspect of development. In this and other writings he illustrated the surprising differences in sizes and shapes of stomachs, livers, and hearts, as well as differences in the lengths and arrangement of colons. The individual differences described by Dr. Williams are important not just in and of themselves but in relation to other individually different organs. For example, the functioning of the heart is of crucial importance to that of the lungs, since it is together that they must provide the brain with oxygen.

Why individual differences matter

What do individual differences in infants matter? Some physical traits matter to the family - a special shape to the lobe or upper edge of the ear, or the impression that the nose "is just like" the mother's or the father's or an uncle's can contribute to the family's feeling that this infant is "our baby," unique like no other. Other individual differences matter for survival: these include the infant's patterns of brain waves and heart rate; the efficiency or inefficiency at sucking; the adequacy of the ability to fend off obstructions to breathing; the tendency to achieve comfort in the crib by kicking off coverings or pushing into a cozy corner; the infant's "sending power," or capacity to elicit help or a playful response from people in the environment. Different maturational patterns of different children may lead to rapid growth, early maturation of skills and early attachment of final height, while slow growth sometimes leads to a longer period of maturation and final greater height. Delay in the age of an infant's ability to walk, however, does not necessarily mean any compromise of his or her capacity to climb a mountain at the age of eighteen.

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Five-week-old André holds his head up as he is held by his father.

It is important to remember that when child development books emphasize the *average* ages for developmental milestones, parents who read them often become anxious if their baby does not attain motor or other skills by (or preferably before) the average age. We need the picture of average development or norms for a *general* orientation to what we can expect of infants and toddlers, but rigid adherence to these norms in planning for babies can blind us to the specific needs of individuals. Knowing that many babies at around eight months experience anxiety with strangers and at separation from mother helps families and professionals to plan carefully — to be sure that familiar persons are with babies when mothers have to go to the hospital, for instance; to help strange visitors avoid close or sudden contacts; and to strive to give babies support and pleasant experiences in the presence of strangers. At the same time, parents who are planning a decision as important as child care for an infant while they work need to consider their own particular baby's unique sensitivity to strangers and to separation. Similarly, pushing a young child to achieve according to some "average" timetable a skill which is developing slowly may convey to that child a sense of inadequacy or inability to meet the expectations of caregivers.

We need developmental norms for a general orientation to what we can expect of infants and toddlers, but rigid adherence to these norms in planning for babies can blind us to the specific needs of individuals.

Many individual differences are subtle but have profound effects on the infant's daily experiences. It is sound to assume differences in every aspect of the nervous system, as individual sectors are involved in altertness, perceptual processing memory, and emotional interactions with thought, perception and memory. The interplay of feelings and response to what a baby sees, hears, touches, and experiences in his insides is reflected in his preferences (for colors, music, soft teddy bears, a comfortable stomach and bath) and in his intolerances. Feeding problems also reflect individual capacities (a need for more frequent and smaller feedings than the average 4-hour bottle contains); differences in tastes (dislikes of sour tastes or of meats); or different degrees of tolerance for delays in feeding.

Because infants differ enormously in their capacities to stabalize themselves, caregivers must observe what a specific infant can or cannot do for himself as well as what he will tolerate or reject. When lacking the attention of a caregiver, one baby may focus on interesting visual stimuli, another suck toe or thumb, and still another play with objects available in the crib. But some babies may give up. The 50% mortality rate in a foundling hospital we observed may have been due both to the lack of tactile and vestibular stimulaton when 11 babies are cared for by one nurse, and to the nurse's difficulty in being able to observe their individual needs and to individualize her care of the babies.

There are many kinds of differences in each sensory zone: a baby may like soft skin contact but dislike bath water or body-play involving rough skin contact; soft sounds are pleasant to one baby, frustrating to another. One baby may be upset at scratchy sounds which arouse the interest of another baby. One baby enjoys music so much that feeding is forgotten when music can be heard, while for another baby feeding has top priority and the music is ignored. One toddler focuses on nearby objects to explore visually, while another scans over a wide range and at a later age asks questions in order to identify objects seen at a distance.

Similarly, patterns of movement vary from one baby to another in range, intensity, tempo, coordination, and purposefulness. Babies use movement differently to obtain and manipulate objects, and in management of their own bodies as well.

More difficult for us to evaluate confidently are differences in memory, perceptual integration, images and fantasy. Infants' excitement and delight at recognition of a favorite toy, animal, or person testify to the existence of memory-images as does fearfulness in re-encountering a previously painful situation, such as seeing the doctor in a white coat who gave the baby immunization injections.

Time is also a factor in individual difference. Individual differences seen at six months of age may undergo more or less change over the next months and years as the environment changes, the baby's genetic potentialities unfold, and biological and cultural interactions exert their influences. In particular, experiences critical for one child may have minimal effects on another. Emotional factors contribute to differences in individual patterns of development. A period of illness may retard motor development temporarily. Some children mature in even steps, while others make jumps in one area while they remain on a plateau in other areas. Some infants, for example, become so excited by new motor skills and the ability to get around and explore that learning more words does not interest them. Other infants and toddlers follow the opposite sequence.

Some basic differences in infants have to be inferred. It is difficult for us to evaluate confidently differences in memory, perceptual integration, images and fantasy.

While differences in level of activity, tempo, smoothness of coordination, expressions of pleasure and social responsiveness are relatively easy to observe, some basic differences are more subtle, or have to be inferred. What is going on in the mind of that baby who endlessly scans the environment, even stretching her head backward as if to see everything? We may say "She doesn't miss a thing." But what sense does she make out of it? We can assume that the baby who deliberately pulls a sheet or a string to bring a toy within reach has a grasp of the relationship between the objects he or she manipulates, but what can we assume about the intensely alert quiet baby? Two-year-old Joyce spent weeks sitting on the edge of the sandbox in the large nursery school playground, just looking and looking. When she spied a weathervane atop a garage 100 feet away and asked, "Chickie?", we guessed that she was endlessly trying to aquaint herself with every part of the playground, and that *complete* *orientation* was more important to her than it was to the children who quickly spotted a familiar tricycle or swing which they could put to use immediately. We did not anticipate, however, that after some weeks of this comprehensive, detailed orientation Joyce would construct the most elaborate block building made by any of the group. Should we have interrupted her way of cognitively mastering the environment and pressed her to get busy on a trike or a jungle gym? She was *not* withdrawn, but another child who sat alone for weeks might have been. How sensitive we must be to the individual child! Not all artists, but some, like Rodin and Rilke, tell us that solitude is necessary for creating. Some of the youngest children can also want peace and quiet and time to absorb their experiences, time to let imagination grow.

Some of the youngest children, like artists, want peace and quiet and time to absorb their experiences, time to let imagination grown.

Individual differences and the environment

It is important for investigators and caregivers to understand the interaction between infants' individual differences and their environments, and how resulting experiences themselves affect the further course of development.

The baby's level and range of enjoyment and of expression of pleasure is a powerful force in his or her many interactions with the environment. A smiling infant irresistably evokes pleasurable responses from adults who are interested in babies, thus initiating and maintaining cycles of joyous interplay which are likely to extend the variety of experiences and of learning opportunities to which the baby is exposed.

The level of activity characteristic of the baby does not by itself tell us all we need to understand about his or her comfort. The capacity for activity is a resource which one infant will use purposefully, resourcefully, oriented to specific goals to reach and to manipulate objects, and to explore the environment. Another baby's activity may be loose, aimless, and poorly coordinated. Such differences are not just constitutional: if the environment is bleak, without available objects; if the infant's efforts to reach out have been interrupted or punished; if objects rapidly lose the baby's interest and become boring, then activity is unrewarding. The baby is less likely to develop a pattern of acting on the environment, to develop the ability to control the environment, and to use activity purposefully.

We also need to assess the balance between the baby's needs and the caregiver's responses. If the baby is demanding, imperious or pleading, does the mother or other caregiver provide appropriate objects or care in such a way as to help the baby become flexible and trusting? One of the most important contributions of mothering is assistance the child's development of flexibility—in the ability to accept substitutes, to wait, to try various ways to meet a need or to satisfy a desire. The Topeka preschool children we saw (studied earlier by Escalona) varied widely in such capacities.

While mothers themselves differ in their energy, time available for the infant, expectations and feelings about the baby, and experience with babies, each baby's own responses, needs and capacities, as well as appearance, evoke different responses from the mother. Her adequate responses, or over- or under-attentiveness to the baby's expressions and efforts encourage, or discourage, the baby's natural out-reaching, active coping. Caregiver responses support or disturb the baby's inner equilibrium. Consequently, after the first year in his or her environment, the baby may be developing patterns quite different from those seen in the first months of its life.

In addition to parents and other caregivers, the infant's environment also includes other members of the family or caregiving group; the physical surrounds, with their sounds, shapes and colors; and the objects available to the child's touch, manipulation, and exploration. The qualities of all of these may be over- or under-stimulating, quite as much as the behavior of people.

The mothers in our study who most easily respected their babies' style tended to have warm, stable marriages. The structure of family life made room for individuality.

It is no small challenge to a parent to satisfy a baby's hunger and activity needs in a way appropriate to a baby's style as he or she grows: pace, bodily rhythms, idiosyncratic comfort patterns, drives and tastes are all involved. The Topeka mothers who spontaneously respected their babies' style were aware of their infants' unique qualities and need to be observed and understood as individuals, not just cared for according to rules applicable to age norms. This was easiest when the mother's own tempo, level of sensitivity and quality of movement did not conflict too much with that of her baby; and when her marriage was warm, stable, with a mutual commitment to "the family unit" as one Topeka father put it. Over a period of two decades there were only three divorces in twenty-seven families in our study; parents tolerated frustrations and balanced bad times with good times. This was the atmosphere in which the children as infants and toddlers were growing; the structure of family life made room for individuality.

Specific experience

Amidst the interaction of so many variables, focus on a concept such as "8 month stranger anxiety" can be misleading. To understand babies' early recognition of, and preference for, mother as compared with strangers, we need studies of individual differences in infants' *experiences*. We need to know about their sensitivities in vision, hearing and touch, and also the specific conditions of early encounters. The loudness, tempo, and

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At 6 months, André races his grandmother in "the crawl."

quality of the stranger's voice; the intensity of colors in the clothing; the manner of approach of and distance maintained by the stranger, all contribute to the specific experience of the individual baby. In addition, the baby's previous experience with new people build expectancies or assumptions underlying the baby's response. A baby who has been living in a large family with friends neighbors is not as likely to be uneasy about new people as a baby who has been cared for by only one caregiver. One of us approached a group of babies in an excellent infant care center; no sign of wariness or anxiety was observed. One of the caregivers commented, "They are used to seeing new people."

Individual differences in coping

Combinations and balances of characteristics are important for a baby's comfort and satisfaction. If the baby is very sensitive to certain kinds or quantities of stimulation, does he or she have ways of protecting himself or herself? If the baby is very active, are coordination, control and direction adequate to enable the child to use activity in satisfying ways? If the baby is attracted by colorful objects, for instance, is initiative available to reach for them?

How do infants vary in their ability to cope with frustration delay, pain and stress? Interestingly, the *range* of stimuli—objects, sounds, motion experiences—to which the baby responds with pleasure seems to contribute to the flexibility with which he or she responds to frustration or delay. In our Topeka study of children's coping, we found that responsiveness to a wide variety of stimuli and enjoyment of social contacts correlated highly with capacity to cope with frustrations, difficulties, and challenges presented by the enrironment. Obviously, environmental support of a baby's positive responses is important to maintain flexibility and adaptability.

An irritable baby may be bothered by any combination of the following: a lack of easy digestion and stomach comfort; discomfort in moving his bowels: skin sensitivity to urine, to sheets, or to clothing that is not soft enough; noises that he finds unpleasant (like the vacuum cleaner or T.V. commercials); overstimulation by colors or by handling.

Mothers and other caregivers are always grateful for the baby who is easily soothed; they may feel frustrated, distressed or even-angry at a baby not easily comforted. Actually, the relation between the techniques of soothing and the individual baby's unique responses may be at fault. While most babies quiet when held up to the mother's shoulder, it is not always possible to do this. It is then that we have to find out whether a "pacifier" nipple, a favorite record on the record-player, or a baby seat moved to a spot with interesting visual stimuli can allow mother to attend to the cooking. Individual babies are likely to be soothed by favorite sensory stimuli; sometimes fussing is an expression of boredom. The baby may need the challenge of something new to see, hear, touch.

> *We found that infants' responsiveness to a wide variety of stimuli and enjoyment of social contacts correlated highly with their capacity to cope with frustrations and challenges presented by the environment.*

Sensitivity to pain and reaction to pain vary dramatically from baby tobaby. One of us recorded the reactions of a half dozen three-month-old foundlings to inoculations: we saw prolonged depression and loss of her usual quick social smiles in one baby girl; hyperactivity, restlessness in another little boy; prolonged uninterrupted screaming for two hours by another little girl—until she was actively comforted by the observer. And memory of the pain varies as well. Dr. David Levy's (1960) study of responses to inoculations reported that one baby cried only when the doctor brought out the needle, and then not until the age of six months; others had cried at sight of the big hospital; and some babies had cried at entering the taxicab to go to the hospital. More studies are needed of individual differences in reaction to other painful medical treatments, of prolonged effects, and of the babies' memories and their related expectations of doctors.

Infants and children differ in their responses to stress. In a routine examination, our pediatrician recorded muscle tension, inhibition of movement, withdrawal of eye to eye contact, crying and other reactions in different preschool children. Tendencies to inhibit action interfere with coping efforts. If a baby is to develop trust in the environment, sensitivity to his or her individual thresholds for and response to stress is crucial. It is important for caregivers to be alert to the individual infant's reaction to stress of different kinds—crying or fussy protests are not the only cues; "freezing," stiffening, widened eyes with an anxious expression, rapid pulse or heart beat, paling or blushing are others. Helping the baby to develop ways of coping with stress, and supporting appropriate efforts when they are made can contribute to the baby's confidence in managing difficulties. Letting the baby kick in the

At 7½ months, Jeremy delights in manipulating his toy

water can help a sensitive baby accept the bath, while energetic business-like washing of face, dipping the head back into the water for a shampoo or hasty cleaning of genitals, can intensify negative feelings about the bath, and about all experience with water. An infant's temperature sensitivity, which contributes to discomfort in the bath, requires help from the caregiver to get a water temperature the baby finds comfortable.

Vulnerability to stress is related not only to the relation between zones of sensitivity and the stimuli of the environment as a whole, but also to individual differences in autonomic nervous system reactivity and related emotional reactions to overstimulation, pain, loss, sudden change, etc. Previous experiences of stress, (as with painful inoculations) that leave an uncomforted memory contribute to further vulnerability to such stress. In other words, individual differences in what is experienced as stressful are in part the outcome of previous interaction between a baby's thresholds for pain and his experience. To some degree a baby learns to be vulnerable and also learns ways of responding to stress—in one case by protesting actively, crying before the doctor produces the needle in the case of infant inoculations; or later, in some cases, trying to avoid or to fend off the threatening stimulus.

Resilience

Resilience has not been studied as much as vulnerability. Among our Topeka children the resilient ones seemed to have a rapid decline of physiological responses to stress after the stressful event, along with resurgence of high drive and responsiveness. By contrast, children with adaptational difficulties recovered slowly from physiological unheavals and also had generally low drive—they were the passive ones. Similarly, the ability of babies to keep on trying after failure (in trying to turn over, to stand alone, to walk) varies widely. Where one baby "never gives up," another apparently feels that "it isn't worth the effort just now". Mary Shirley documented these differences in learning to walk.

The kinds, degrees, and frequency of frustration to which an infant is exposed may exceed his ability to cope or deal with it. Parents who stimulate, then withdraw or otherwise tease a baby may cause persistent frustration, leading to chronic distrust of the environment. Infants and toddlers very in their empathy and identification with others' distress and moods. If adults in the environment are ill, depressed or suffering, the burden on the child may depend on both the sensitivity of the child to suffering and the amount of distress to which the child is exposed.

Among the Topeka children, those who showed most continuity had greater developmental balance and less vulnerability in infancy, and were growing up in environments which were relatively homogeneous, stable, free from traumatizing vicissitudes and congenial to the child's natural style of development.

The infant: a complex dynamic system

Neurology and neuropsychology, as well as biochemistry, anatomy and child development all add to the picture of the range of individual differences in every aspect of the organism and to the resulting complexity of the unique outcomes of their interactions. In other words, individual differences are not a matter solely of specific genes and the specific characteristics to which they give rise; new individual patterns emerge from *the interaction* of these tendencies. As if that is not complex enough, different individual aspects of the environment interacting with the infants' own patterns contribute to new outcomes.

All of this means that the infant, seen biologically, is an awesomely complex dynamic system with subsystems interacting with each other. Differences in individual thresholds for stimulation in every sensory zone, and in the pace of processing between systems and in coordination of motor responses, as well as the pace of formation of internal images and schemas, underlie the great differences in response patterns that we see in different babies. And this means difference in a baby's style and in a baby's capacity for coping with the world.

There are potentialities for both pleasure and frustration inherent in the individual patterning of genetic tendencies, as well as in the range of interactions with different aspects of the environment. We still have much to learn about the interplay of different constitutional tendencies within the child and between the child and the complex personal and impersonal environment.

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The "Gourmet Baby" and the "Little Wildflower"

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Nine-month old Eric is typical of a phenomenon that has come to be known in the popular media as the "gourmet baby." He has two educated, professional parents who have delayed childbearing until their early thirties. He has all the best baby equipment that money can buy—the right furniture, the right stroller and a genuine shearling cover for his car seat. Eric has swimming lessons, looks at flash cards of famous paintings and simple words, plays with the best "developmentally engineered" toys and will begin the study of the violin in a year or two. He also has enough stimulation in the course of a day make even a college student want to take a nap and shut it all out—which is just what Eric does.

The "gourmet baby" will grow in a few short years into the "hurried child."

The gourmet baby will grow in a few short years into David Elkind's "hurried child." The gourmet baby's parents are already investigating the "right" nursery school, the best grammar school, the most prestigious college. If the parents both work, they are desperately trying to pack what they think of as "quality time" into evenings and weekends. If the mother does not work outside the home, she has made a deliberate decision to stay home to be a "professional parent."

Although some observers have labeled the gourmet baby as a "yuppie" invention, others have noted that, like their designer clothes, gourmet babies can be found in families at all economic and social levels. It is particularly tragic that among the most susceptible to the trappings of consumerism are the parents of at-risk infants, such as teenage parents. The gap between what they see promoted as the best products for children and what they can actually buy tends to increase the alienation from the rest of society that they already feel.

The proliferation of gourmet babies

What has caused the proliferation of gourmet babies? First, societal changes such as new family work patterns, delayed child-bearing and smaller families have contributed. Because of economic and social pressure, both working mothers and their stay-at-home counterparts are vulnerable to different kinds of guilt: the guilt of not contributing more to the family finances or the guilt of spending too much time away from children. That guilt, added to parents' natural pride in their children and desire to give them the best, materially, intellectually and emotionally, has resulted in an intense concentration on the infant as both evidence of and justification for the parents' lifestyle.

Another contributing factor may be the movement away from regular contact with distant grandparents and other older and wiser relatives. There is often no one parents can turn to for childrearing advice, and no one to say to them, "I think babies don't care how expensive their clothes are . . . The baby seems tired of this game," or, more important, "Trust your instincts." Middle-class parents turn instead to various kinds of professionals and to popular books to tell them how to raise their children. And working-class and welfare parents often lack even these sometimes ineffective resources.

There is often no one around to say, "The baby seems tired of this game."

As a result of guilt, anxiety and isolation, too many parents focus on the obligations of childrearing without ever knowing the pleasures that balance the responsibilities. They suffer from the mistaken notion that "quality time" can be programmed in the absence of enough "quantity" time to allow for spontaneity in the development of both child and parent. The unnecessary material trappings that are showered on the gourmet baby—whether or not the family can afford them—are only a part of the phenomenon. The major element that characterizes the parent of the gourmet baby is the relentless and sometimes joyless pursuit of high-intensity learning experiences for the child, beginning in infancy and toddlerhood.

Bookshelves in the gourmet baby's home are likely to contain titles such as *How to Teach Your Baby to Swim, Yoga for Children, How to Teach Your Baby to Read, How to Teach Your Baby Math, How to Make Your Child a Genius* and *Test Your Baby's IQ*. (Believe it or not, all these books exist.) Special programs for infants and toddlers, usually available for a fee, are parent-child gymnastics, Suzuki music lessons, and reading programs offered by mail by organizations such as the Better Baby Institute or the Children's Reading Institute. Some of these organizations offer courses that parents can attend in order to perfect their techniques in teaching infants and toddlers a variety of subject matter—foreign languages, history and science.

Researchers and professionals also note that the gourmet baby phenomenon has occurred in conjunction with the recent explosion of information about the newborn's abilities. Around the turn of the century, early psychologist William James saw the infant's world as one of confusing sounds and blurry, shifting images. Yet now researchers can demonstrate that newborns possess rudimentary abilities to perceive, organize and respond to information. The knowledge that infants can learn, and that they are indeed learning from the moment of birth, has rocked not only the study of developmental psychology but also the public imagination.

BARBARA HADLEY

Ironically, the public perception of such research can lead to two extreme opposite views of childrearing—the gourmet baby or "hothouse plant" approach and the "little wildflower" approach. Because babies know and can do more than was previously thought, we can choose to capitalize on their abilities and "fertilize" them with artificial stimulation until we develop improved hybrids or "better" babies. Or we can relax and assume that nature has programmed the little wildflowers to bloom, and that our only task is to observe their physical, intellectual and emotional growth.

The "little wildflower" approach

Daisy is being raised as a typical wildflower baby. She is dressed in practical clothes and has no fancy toys or lessons. Her parents both work outside the home, and she has had an assortment of babysitters in her first year, chosen according to cost and her parents' convenience. She is allowed to crawl and explore throughout her own house, but sometimes one of the babysitters leaves her in a playpen for most of the afternoon. On those days, she seems a little cranky in the evening, but her mother and father assume that Daisy will always "land on her feet," and that none of this disorganization in her environment will have any effect on her in the long run. Her parents are as interested in their child's learning as are Eric's parents, but they believe that learning is taking place naturally, that natural is always better and thus that everything Daisy learns about her world is good.

The nature—nurture debate revisited

What we are seeing replayed in both the gourmet baby and little wildflower styles of childrearing is the two sides of the old nature-nurture debate. A child's learning process was seen by some philosophers and early behavioral psychologists primarily as a result of experience or nurture. However, the works of Gesell and other developmental psychologists emphasized learning as a naturally unfolding, sequential process—that is, they seemed to be on the side of nature.

JANET BROWN McCRACKEN

During recent generations, the pendulum of thought has at times swung toward an emphasis on nurture or environment and at times toward an emphasis on the child's own natural maturation and motivation. Shortly after the launching of Sputnik in the 1950s, a point of view dominated the philosophy of childrearing and education in this country that the first author has referred to as "the environmental mystique." In its simplest form, the environmental mystique holds that intelligence is essentially trainable: that the intellect, or collection of cognitive processes, is the result of environmental input. A book by J.M. Hunt, *Intelligence and Experience*, was the theoretical treatise that most exemplified this argument, and as a work of scholarship was quite fascinating to psychologists.

However, Hunt's work suffered considerably in translation to laymen, and two problems arose. First, parents, teachers and others began to emphasize the building of cognitive processes in children and to de-emphasize the support of the child's natural thrust toward cognitive maturity, understanding, independence and social competence. Second, in pursuit of the goal of cognitive development, parents got the idea that small environmental changes—the right kind of mobile hung over the baby's crib, for example—could result in significant cognitive differences in later life. Naturally, they also worried that minor omissions on their parts—the lack of a mobile—could have an equally strong negative impact on their children's intelligence.

Both natural ability and environment play a part in the development of the child, and childbearing and educational practices should reflect a balance between the two.

In formulating theories of development, and especially in explaining those theories to the beleaguered parents of infants and toddlers, professionals must take both nature and nurture into account. Both natural ability and environment play a part in the development of the child, and childrearing and educational practices should reflect a balance between the two.

Although research in cognitive processes continues, present knowledge supports certain statements about development and learning. First, children do go through various developmental stages, including cognitive, physical and socio-emotional ones. Second, all normal children go through the same stages sequentially, although at different rates. At each stage, the child develops certain new skills and becomes ready to advance to the next stage. Two factors determine what brings a child out of one stage and into the next: biologic maturation (or "readiness"), as emphasized by Gesell and more recently by Jerome Kagan, and a certain amount of experience, as emphasized by Piaget. Third, the individual child's reaction to the environment is never passive. Experience cannot be given to a child, but requires the active participation of the child. Thus, the quantity and the quality of learning that goes on is influenced by genetics, by individual temperament and by other factors.

In the light of the above consensus about development, the gourmet baby approach generates certain concerns. First, the belief that middle class parents can increase their infant's or toddler's cognitive development or later school success by pressured learning programs is erroneous. In the absence of specific developmental problems, long-term benefits of accelerated learning programs have not been demonstrated by sound research. Infant IQ measures now generally used do not correlate well with school-age IQ scores, and learning in any area is subject to the child's readiness to advance to the appropriate stage. This does not mean that parent-child interactions have no effect on cognitive development. Bornstein's recent work at New York University on continuity in mental development over time suggests the opposite. However, the kinds of intense, accelerated programs in vogue with parents of gourmet babies are a far cry from the beneficial interactions between mothers and infants that Bornstein has observed.

The second concern with the gourmet baby approach is that when parents emphasize cognitive learning to the exclusion of physical and socio-emotional development,

ZACHARY SCHRAG

they run the risk of interfering with the other developmental tasks of infancy and toddlerhood by reducing or eliminating play. Third, and most important, pushing children to achieve beyond their capacity interferes with the child-parent relationship, and sets the stage for mutual disappointment and resentment. Parents should be sure that the experience of learning for infants and toddlers is a joyful one, and that they allow unstructured time in which not only cognitive but also other types of learning can take place.

In recent years, the emphasis that specialists and program directors have placed on "parents as the child's first teachers" has de-emphasized parents as parents. Parents should be encouraged to reaffirm the special relationship between parent and child. Some of the best and warmest moments that parents and children remember for a lifetime happen quite spontaneously in the course of the everyday round of activities when parent and child are together. On some occasions, cognitive learning takes place, such as the chance observation of a bird making a nest. At other times, parent and child may simply be surprised by the feeling of each one's special value and love for the other. Whether or not both parents work, they should allow a certain amount of unscheduled time, during which there are no toddler gymnastics, violin lessons or alphabet games planned, for parent and child to be available to one another.

This does not mean, however, that parents should not plan any activities with their children. Appropriate activities from infancy to age three range from mimicking the child's spontaneous sounds in the first months to naming objects in the environment and conversations about what the child sees and experiences as vocabulary and sentence structure are learned; from singing and rocking an infant to looking at picture books with a toddler and reading aloud. Parents of under threes should avail themselves of library story hours and other similar resources offered free in the community. Read-aloud programs and materials that are designed to encourage a love for reading when the child is ready are offered by a number of excellent publications.

The above activities only serve to illustrate a balance that both parents of little wildflowers and parents of gourmet babies can be encouraged to strive for. While not pinning all their hopes on manipulating the home environment, parents need nonetheless to be aware of the quality of that environment and others (such as child care) that the child experiences. There is a level of quality in these environments that must be maintained for normal development to take place. Experiencing environments below a minimum quality or threshold can cause delays in physical, cognitive and emotional development. For example, a child needs a certain amount of physical nurturing and protection — a balanced diet and a physically safe environment — in order for healthy development to continue. Given that minimal threshold, infants and toddlers may be viewed as basically resilient, as long as they are not taxed beyond their individual capacities to adjust. For example, a good quality environment provides for consistency in the child's main caregivers. Most young children are able to withstand a one-time change in substitute caregivers, although a change is likely to occasion a period similar to grief, during which all or some areas of development are affected. Sensitive children who balk at all forms of change, including new foods and temperature changes, will most likely experience a more difficult adjustment to an event of such significance.

Whether or not both parents work, they should allow a certain amount of unscheduled time for parent and child to be available to one another. Parents and children often remember for a lifetime moments that happen quite spontaneously, as they feel each one's special value and love for the other.

The more stresses are added to a child's situation, which includes such physical elements as diet and illness as well as the emotional climate of the family, the more taxed the child's ability to adjust will be. Although Daisy's parents had the right idea about the importance of exploratory play in their child's development, they took no notice of the need for consistency in her relationship to reliable caregivers and in child-rearing styles. Raising children in the manner Daisy's parents have adopted also assumes a friendly environment in which there are no emotional or physical dangers. Although parents should be more relaxed in their interactions with their children than are the parents of gourmet children, they should be clear about potential hazards in the environment and take reasonable precautions to guard against them.

There are other major factors in the environments experienced by many children in this country about which both the parents of gourmet children and those of little wildflowers are only dimly, if at all, aware. Those children most at risk are the ones who suffer day by day the debilitating effects of the larger environment that extends beyond the home and childrearing styles. Inadequate housing and nutrition, poor or nonexistent health care and lack of protection from injuries and violence are all environmental factors that have been identified as having negative impact on the development of children. Children who endure these experiences, as well as children who are at risk of developmental problems because of physical, emotional and cognitive disabilities, are the ones who most stand to benefit from research and prevention programs. Ironically, it is the publicity around the beneficial effects of intervention programs for this group of children (and, to an equal extent, fears about the effects of substitute child care *per se*) that has contributed to the preoccupation of the middle class with the effects of the environment on their own children.

Those children most at risk
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and childrearing styles.

The parents of gourmet babies have themselves been raised in the era predominated by the environmental mystique. They are already aware that environment and experience help to determine to some extent the cognitive development of children. What they have yet to learn is that development is multi-faceted, that all aspects of development need room in order to take place. In the last analysis, the best thing professionals can do for gourmet parents is one of the things they also must do for parents of at-risk children who are in intervention programs: encourage them to allow their children to play, to play with their children and to permit themselves to experience the incomparable joys of parenting.

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Perspectives on Practice:

The Family Room

by
Susan H. Burke
Arizona Department of Health Services

Joani Share
ARTicipate

If you've seen one waiting room, you've seen them all? Well not anymore! The FAMILY ROOM, of the Newborn Followup Clinic, is a waiting room unlike any other. This room is small in dimensions but enormous in outcomes. In 100 square feet of space it provides more client-oriented services than hospital waiting rooms ten times its size.

The Newborn Followup Clinic of the Arizona Department of Health Services, Office of Maternal and Child Health (MCH), is designed to provide followup services for children who received intensive care at birth. Statewide responsibility to ensure this early intervention prompted the establishment of developmental followup clinics in the two major metropolitan areas of Arizona, Phoenix and Tucson,

Originally established at the Arizona Children's Hospital, the Newborn Followup Clinic recently found itself relocated to a central Phoenix office building close to the three major hospitals which provide pediatric intensive care. Budgetary restraints at the time of the move dictated that the clinic would be forced to make do with discarded waiting room furniture not wanted by other agencies.

The staff of the Newborn Followup Clinic, including doctors, therapists, developmental specialists, and administrative and clerical personnel, realized that the waiting room for the facility should help set the tone for the client's visit. It was readily apparent that a more child-oriented environment was needed, one which was: 1) user-friendly, 2) aesthetically pleasing, 3) able to model appropriate activities, 4) practical, and 5) able to meet the needs of families "waiting."

Applying for funding from outside sources proved to be unsuccessful, but staff found that memorial donations to the hospital, which had been collected over the years, might be available. The project received overwhelming support from the families involved. The Newborn Followup Clinic was now ready to solicit proposals from organizations with backgrounds in both child development and room arrangement for the design and implementation of the waiting room project.

"ARTicipate," a Phoenix-based company that creates child-oriented spaces, responded to the proposal with an innovative plan. Using the specified framework, the plan effectively incorporated, within 100 square feet, space for children and adults. ARTicipate's major concept was to create an environment which simulated a home-like atmosphere while including varied educational activities. Materials were designed so that they were not only educational but so that they could be

ARTicipate

easily replicated by parents or anyone else using the facility.

The waiting room, now called the FAMILY ROOM, began to take shape as a small maze of interrelated areas. Organization and space demanded that each area be clearly delineated, material storage be easily maintained, and little explanation be needed for participation. These requirements resulted in each portion of the FAMILY ROOM having unique equipment and definition of purpose. An alcove was designed for mobile and non-mobile infants and toddlers. The main consideration for this area was a wide range of textures and visual stimulations. This space has a mirror at floor level with a soft, fluffy rug placed directly in front of it. Brightly colored plastic storage-bin shelves house a variety of soft toys, stackables, and rattle-type equipment. All are in reach of the crawling baby. Other sections of the FAMILY ROOM include a kitchen/dramatic play corner, a child-sized couch for sitting or reading, an area for art and creative media, and a place for manipulatives and games. This manipulative area is defined by a child-sized table and two chairs, plus a shelving unit which contains numerous games and activities. The wide range of materials is designed for all ages, abilities and levels of interest. Since each toy is stored in its own container, children can play and then upon completion can easily put the materials away. Parents learn that this type of organization helps their children become independent, and children learn to put away materials with little frustration. Staff also can easily sort and maintain materials and place mismatched items in the appropriate container.

Parents are a very important part of the successful implementation of the FAMILY ROOM. A parent observation area borders the room but does not interfere with the children's play space. Every item in the FAMILY ROOM, including all games, toys, and equipment, has been documented and recorded in a resource book which is made available to all families in the program. The parent support group, ICU Care Parents, is selling this book as a fund raising project.

It has been five months since the opening of the FAMILY ROOM. The conversion from waiting room to FAMILY ROOM has been far more successful and well received than ever imagined. Families interact differently with each other and with the staff. Parents are more open and receptive. Children have constructive activities to fill their time so that they are more relaxed and ready for their appointment. The visit actually is pleasant for families! The environment is so child-oriented that it is difficult for parents to coax their children out the door when it is time to leave.

The FAMILY ROOM has also had a profound effect on the staff. It is not uncommon to hear: "Parents are playing on the floor with their baby!"; "Can I get my exam room redone too?"; and "I was stopped and served pretend oatmeal on my way to the copy machine." Therapists feel that test results are now much more reflective of the children's actual capabilities and developmental levels since the children feel so comfortable in the environment. Staff is exploring ways to change the examination rooms so that assessment can occur through the chid's natural use of the environment instead of through contrived situations. Therapists often use the FAMILY ROOM as a test site, because it simulates the children's real world.

The FAMILY ROOM of the Newborn Followup Clinic is very special. It is a small room, but the 1,000 children who visit it anually know that it has a big impact.

The FAMILY ROOM BOOK and program
information can be obtained from:
Susan Burke
Arizona Department of Health Services
Newborn Follow-up Clinic
3008 North Third Street
Phoenix, Arizona 85012
(602) 241-9500

Children's Environments can be obtained from:
Joani Share
ARTicipate
726 E. Solana
Tempe, Arizona 85281
(602) 967-5473

National Center Notes:

By Eleanor S. Szanton

The twin publications, **Infants Can't Wait** and **Infants Can't Wait: The Numbers,** are now available by writing to our office.

The first publication, **Infants Can't Wait,** designed for policy-makers, funders and concerned individuals at the national, state and local level, reviews the developmental tasks and needs of infants and toddlers, describes the support for healthy development currently available in this country, and then calls for two major initiatives to address the remaining unmet needs. These initiatives are: 1) **the establishment of a basic floor of integrated services for all infants and toddlers and their families;** and 2) **the expansion of comprehensive, integrated services for infants and toddlers with special health and developmental problems or disabling conditions, and their families.** Suggestions for implementation are made for various levels of government and for the private sector. Recommendations for basic services deal with issues of financing; the availability of health, nutritional and child care services; and economic and social supports to families. Recommendations for infants and toddlers with special problems include various forms of therapeutic and respite care and the integration of services for families, including those who may be particularly hard to reach.

Infants Can't Wait: The Numbers draws together as much information as possible on the status of infants and toddlers in this country. Compiled largely from government sources, the statistics summarize infant births; the circumstances of their families; the risks to life and health our nation's infants are facing in the first years of their lives; the family and community environments in which they develop; and the sources of health care available to them. Readers of this document will discover data which vary enormously in depth and detail. This is so because, unfortunately, major aspects of the lives of infants and young children are sparsely sampled or ignored altogether in data gathering by the federal government. *Yet the ability of a society to mount effective programs to prevent illness and disability and promote healthy development is intimately connected with its knowledge of what exists.*

Three generalizations leap out from the data collected: First, the earliest years of life are a particularly vulnerable time. Secondly, while most of our children have an excellent start in life, a worrisome number bear multiple burdens from the very beginning of their lives. Finally, primary health care for infants and toddlers focuses on curing illness rather than prevention.

These truths are apparent as "The Numbers" are compiled on infant birth weight, mortality, family characteristics, incidence of disabling conditions, incidence of exposure to toxic substances *in utero* and after birth, incidence of mental health disorder, failure to thrive, accidents, and child abuse. They are raised again with a recital of the circumstances of infants' daily care, nutrition and health care. The multiple risks faced by a significant number of our nation's infants represent multiple areas of inattention to their needs, particularly in comparison to other countries.

Infants Can't Wait and **Infants Can't Wait: The Numbers** are available by writing to NCCIP. (See coupon on page 19).

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NCCIP does see significant progress in the willingness of a number of states and localities to design a comprehensive continuum of services (both public and private) for all infants and for those with special needs. Happily the perspective seems to be changing from one of "what we offer" to "what is needed." In this spirit, the National Center for Clinical Infant Programs, with support from the Division of Maternal and Child Health, U.S. Department of Health and Human Services, convened a multidisciplinary group of seventeen individuals experienced in the identification and evaluation of high-risk infants and young children. The group developed a set of criteria, any one of which should assure a young child "at least one more look" by a qualified infant/toddler specialist.

Warning Signals: Basic Criteria for Tracking At-Risk Infants and Toddlers by James Blackman, M.D. is the product of the group's effort. The 10-page booklet lists two sets of criteria. Those criteria applicable to a newborn, or to an infant before discharge from the hospital to home, include both parental/psychosocial factors that may affect the fetus or infant and characteristics of the newborn. Those criteria applicable to a child from birth to three, living in the community, address issues regarding health maintenance, newly diagnosed familial disorders, growth or nutritional problems, insults to the central nervous system, severe chronic illness, and atypical or delayed development.

Warning Signals is designed for an audience of parents, professionals, policymakers and administrators. It describes risk factors and their possible developmental consequences in non-technical language. Copies of **Warning Signals** are available free of charge from the National Maternal and Child Health Clearinghouse. (See coupon on page 19).

The September, 1986 issue of Zero to Three, which focused on aspects of child care for infants and toddlers, has occasioned a number of deeply felt responses from our readers. Additional perspectives on this important area of concern will be published in our February, 1987 issue.

For Your Information:

The Education of the Handicapped Amendments of 1986 (P.L. 99-457) were signed into law on October 8. The Act creates a new discretionary program with funds for states to address the needs of disabled and at-risk infants, toddlers and their families; it also provides incentives to states to serve an estimated additional 10,000 handicapped children ages 3 through 5.

A 99-page report of the House Committee on Education and Labor describes the background and need for the legislation and the rationale underlying various provisions; it also provides a section-by-section analysis of the Act. Single copies of Report 99-860, the Education of the Handicapped Act Amendments of 1986, are available free of charge from the Senate Document Room, Hart Senate Office Building, Room B04, Washington, DC 20510-7106. Requests should be accompanied by self-addressed gummed labels.

At the federal level, development of regulations for P.L. 99-457 is proceeding at the Department of Education. Preliminary regulations will be published in the Federal Register, and a 60-day comment period will follow. Meanwhile, in the states, governors will be deciding whether to apply for available funds to provide early intervention services for infants, toddlers and their families. To receive a grant for the first two years, a governor must designate or establish a lead agency or entity as a single line of authority for overall administration of the program. The governor must also establish an Interagency Coordinating Council which by the third year must include relevant agencies, consumers and providers. Because circumstances differ from state to state, *Zero to Three* readers may wish to contact their governors' offices to express their interest in the new legislation and to learn how to participate in planning for their state.

The Sixth Omnibus Budget Reconciliation Act of 1986 (SOBRA - P.L. 99-509) permits states to expand Medicaid eligibility to pregnant women with incomes up to a state-established threshold that does not exceed 100 percent of the federal poverty level ($8,800 annual income for a family of three in 1986). States have the option to: 1) provide prenatal, delivery and post-partum services for up to 60 days to all pregnant women and 2) provide Medicaid coverage for infants up to 1 year of age regardless of family structure. With annual increments states can also include children up to age five in their Medicaid program. The American Academy of Pediatrics estimates that between 3 and 6 million children could be added to Medicaid if every state adopts the new option. The new options become effective April 1, 1987.

The Department of Special Education at the University of Maryland has received a new personnel preparation training grant for its masters program in early childhood special education. Students are trained to work with children from birth to five years with varying handicapping conditions. Supervised apprenticeship placements are at home- and center-based interdisciplinary intervention programs, diagnostic centers and hospital based programs. Contact Dr. Paula Beckman, Department of Special Education, University of Maryland, College Park, MD 20742, tel: (301) 454-2118.

The Infant Mental Health Service of the Community Mental Health Center of the University of Medicine and Dentistry of New Jersey (UMDNJ) is offering a new two-year psychodynamically oriented training program in infant mental health. The program consists of didactics; clinical experience; and participation in clinical research, publication, formal presentation, teaching and consultation. Eligible candidates must be accredited practitioners in the fields of psychology, psychiatry, pediatrics, social work or pediatric nursing. Trainees will be expected to participate for a minimum of two full days per week in training and service activities. For further information contact Thea Bry or Susan Adubato, Infant Mental Health Service, CMHC/UMDNJ, 100 Bergen Street, Newark, NJ 07103, tel: (201) 456-6831.

Polymorph Films, a national distributor of film and video programs on maternal and child health and child development, is seeking locally produced films and videos on these topics that are suitable for national distribution. Contact Alvin Fiering, President, Polymorph Films, Inc., 118 South Street, Boston, MA 02111, tel: (617) 542-2004.

Corrections: The September, 1986 issue of *Zero to Three* should have been identified as Volume VII, Number 1. The correct address of Victoria Levin, who can provide information on grants to young researchers, is Center for Prevention Research, NIMH, Parklawn Building, Room 14C03, 5600 Fishers Lane, Rockville, MD 20857.

REGISTER NOW FOR NCCIP'S SPRING 1987 REGIONAL CONFERENCES

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See Conference Call, page 20 for more information.

Publications:

Understanding Mental Retardation—Edward Zigler and Robert M. Hodapp (New York: Cambridge University Press, 1986), $11.95, paperback.

This volume represents an attempt to provide a unified treatment of the field of mental retardation. It summarizes the authors' 25 years of research and thinking on mental retardation from a developmental perspective and also presents new ideas that are likely to be extended and studied further in future years.

Chapters on "What we do and do not know about mental retardation" and "The developmental perspectives" are designed to be introductory in both content and style. The developmental perspective emphasizes that retarded and nonretarded children go through a similar sequence of development, have a similar structure of intelligence, and react similarly to environmental forces. In a section on intervention and treatment approaches, a chapter on "Early intervention programs and their evaluation" reviews and discusses the Abcedenarian, Milwaukee, Perry Preschool and Yale Child Welfare Research Projects; it also provides recommendations for evaluating early intervention programs. In "The search for miracle cures," the authors consider vitamin therapy and Doman-Delacato procedures, concluding that "There is not, nor is there ever likely to be, one cure for mental retardation."

Early Identification of Children at Risk: An International Perspectives—William K. Frankenburg, Robert N. Emde, and Joseph W. Sullivan, editors (New York: Plenum Press, 1985) $42.50.

Based on presentations at the Fourth International Conference on Children At Risk (1984), this volume reflects growing international recognition of the importance of early identification and rehabilitation of handicapped children. The editors also recognize that no single approach to the early identification of children at risk is universally applicable to all countries: 75 contributors represent many professional disciplines as well as thirteen nations.

The volume includes an historical perspective on early identification of children at risk; five chapters on the at-risk child in the social environment; new and updated approaches to screening, including chapters on screening instruments, selective follow-up of at-risk populations, and experimental efforts; and fifteen chapters describing regional and national programs of early identification.

Beginnings: The Social and Affective Development of Black Children—Margaret B. Spencer, Geraldine K. Brookins, and Walter R. Allen, editors (Hillsdale, New Jersey: Lawrence Erlbaum Associates, Inc., 1985) $34.50.

This volume is a product of three years' effort by a study group, the idea for which originated at the 1975 meetings of the Society for Research in Child Development. The editors describe the purpose of *Beginnings* as "to redifine how black children and their families are treated in the literature."

Twelve original empirical studies, which form the core of the volume, address issues of social competence, identity, and family (none of these deals specifically with infants toddlers and their families.) Four introductory papers offer contrasting perspectives for the scientific study of minority child development.

The editors see this volume as a first step in examining "the culturally organized child socialization formulae which connect black children's life circumstances and their development of necessary survival skills." Among the issues they see as important items on a research agenda for the future are interactions between class and culture in black life; implications of changing family structure, bio-psycho-social factors in black child development; and ecological determinants of black child development.

Stimulation and Intervention in Infant Development: Theories, Evaluation and Research, Programs in the Community, Fetal Behavior and Intervention for the Child at Risk—Dov Tamir, T. Berry Brazelton and Alex Russell, editors (Freund Publishing House, Ltd., Suite 500, Chesham House, 150 Regent Street, London W1R 5FA, England, 1986) $24.00.

This book is based on the First International Symposium on Intervention and Stimulation in Infant Development, held in Jerusalem in July, 1984. Forty-five papers are grouped into five units concerned with: 1) the conceptual basis for intervention in child development; 2) intervention programs in a variety of health, child care and community settings; 3) identifying and working with children at risk for developmental disabilities; 4) fetal development; and 5) diagnosis and evaluation in child development.

Examined in some detail is a project of the Municipality of Jerusalem in which trained professional instructors work in specially designed and equipped "corners" of neighborhood mother and child health centers. The instructors observe parent-child interaction as parents and infants play while waiting for check-ups. The instructors evaluate the baby's developmental status and demonstrate and explain it to parents; provide anticipatory guidance and instruction in making and using developmentally appropriate play materials made from household or scrap materials; and model attitudes and practices designed to encourage infant development.

Low Achieving Children: The First Seven Years—Sarah Broman, Ellen Bien and Peter Shaughnessy (Hillsdale, New Jersey: Lawrence Erlbaum Associates, 1985) $19.95.

This volume is the second major report on the intellectual development of 35,000 children studied in the Collaborative Perinatal Project conducted at 12 different research centers over a 25-year period beginning in 1959.

The project's first major report of developmental outcomes analyzed IQ scores of the sample when the children were four years old. The intellectual outcomes for children were far better explained by the eight family factors examined than by any combination of the 161 biomedical variables considered.

This report focuses on the approximately one thousand children in the study identified at seven years of age as having normal intelligence but showing poor school performance; this cohort was compared with more than 4,000 children who had normal school performance. While this study investigated a broad array of prospectively determined physical, social and behavioral characteristics, these had only moderate power to explain low school achievement. Major findings in the study did, rather, support and augment the conclusion of other investigators that lower socioeconomic status, less maternal education, higher birth order and larger family size are related to higher rates of academic failure.

Drug Use in Pregnancy: Mother and Child—Ira J. Chasnoff, editor (MTP Press, 101 Philips Drive, Norwell, MA 02061, 1986) $35.00.

In his introduction to this volume, Kenneth Kaye suggests that "It would be a vast oversimplification to conceptualize the problem of substance abuse in terms of effects of drugs upon the developing fetus and child and consider nothing more than that . . . Whatever effects drug abuse has upon the fetus, its effects are likely to make themselves felt upon the developing child through a multi-layered interaction (influenced by factors including) the infant's neurological system, the parents' sensitivities, the infant's intelligence and the parents' expectations . . . It is the pathological system, not the drug use alone, which must be addressed in any therapeutic endeavor."

Chapters in the volume discuss the pharmacologic basis of perinatal addiction as well as consequences of intrauterine exposure to opiate and nonopiate drugs and the use of marijuana, alcohol and psychotropic drugs in pregnancy. A review of variables which might relate to poor interaction between chemically dependent mothers and their infants suggests three potential causes for interactional pathology: 1) the stress created for mother and child by the infant's withdrawal symptoms after delivery; 2) tendencies toward personal and social instability among drug-abusing mothers; and 3) the high incidence of severe social isolation among drug-abusing mothers and their infants.

Developmentally Appropriate Practice—Sue Bradekamp, editor (National Association for the Education of Young Children, 1834 Connecticut Avenue, NW, Washington, DC 20009-5786, 1986) $3.00.

This publication of the National Association for the Education of Young Children attempts to describe developmentally appropriate practice in early childhood programs serving children from birth through age 8. The concept of *developmental appropriateness* is seen as including dimensions of both age appropriateness (based on knowledge of predictable sequences of child development) and individual appropriateness (recognizing each child's unique personality, style and background). Concerned about increased emphasis on academics in early childhood programs, NAEYC emphasizes that "programs should be tailored to meet the needs of children, rather than expecting chidlren to adjust to the demands of a specific program."

The section on developmentally appropriate care for children from birth to age three was written by J. Ronald Lally, Sally Provence, Eleanor Szanton and Bernice Weissbourd, members of the Day Care Committee of the National Center for Clinical Infant Programs. It describes the different competencies and needs of very young infants; "crawlers and walkers"; and toddlers and two-year-olds. Developmental milestones for each group are charted in terms of interest in others; self-awareness; motor milestones and eye-hand skills; language development/communications; physical, spatial and temporal awareness; purposeful actions and use of tools; and expression of feelings. Case vignettes illustrate basic elements of appropriate care.

The section on integrated components of developmentally appropriate practice for infants and toddlers is designed for practitioners in group settings. Both appropriate and inappropriate practices are described, in the belief that people often understand a concept most clearly if they are presented both positive and negative examples.

Better Baby Care: A Book for Family Day Care Providers—Margaret Nash and Costella Tate (The Children's Foundation, 815 Fifteenth Street, N.W., Suite 928, Washington, DC 20005, 1986) $12.95.

This 150-page book, funded in part by grants from the A.L. Mailman Family Foundation and the Foundation for Child Development, is designed for child care providers who do not have access to in-service courses or as a text for training programs. Language is easy to read, print is large, and many drawings and photograph are included.

The book includes information on arranging the home for infant care; nutrition and feeding; health and safety; business procedures; relationships with parents; and infant development. Concepts of attachment and self-esteem are discussed in a chapter on "Baby's Beginnings." The chapter on "Understanding Infant Behavior" describes "fussy," "jumpy," or "timid" babies and approaches to caring for them; this chapter also discusses behaviors such as temper tantrums and biting that may be difficult for caregivers to understand and deal with.

Day Care's Unfair Burden: How Low Wages Subsidize a Public Service—Caroline Zinsser (Center for Public Advocacy Research, Inc., 12 West 37th Street, New York, NY 10018, 1986) $3.00.

This 29-page report summarizes a year's study by the Center for Public Adcocacy Research on day-care worker compensation in which data were analyzed from 451 day care centers in New York state representing 4,844 employees.

The report found that the annual wage per child care employee was $7,893 in New York state, with head teachers (of whom 84% in the survey were college educated) earning an average of $6.23 per hour. Average staff turnover rate was 40% for teachers. Many child care employees work at second jobs. Day care directors reported difficulty finding qualified applicants, and two-year training programs reported few students.

The report makes eleven policy recommendations, including: increased government funding for subsidies, employee benefits and training; salary schedules equivalent to those in local public schools: career ladders; and organization of child care workers.

Audiocassettes:

The Media Group at Bank Street College of Education, the **Child Care Action Campaign (CCAC),** and **John Merrow Productions, Inc.** have published a set of three 30-minute audiocassettes on "Health and Safety" for family day care providers. Based on material recorded in the homes of actual providers, the cassettes provide information on healthy routines, sickness and emergencies, and safe play indoors and outdoors, with a special segment on kitchen and bathroom safety. The providers interviewed describe their own strategies for creating environments and routines that are safe but not restrictive for young children and that make their own work easier. In the context of discussion of health and safety issues, providers also stress the importance of emotional warmth in the family day care home and attention to the individual needs of infants and toddlers.

The "Health and Safety" set of three cassettes, together with a reference booklet, is available for $15 plus $2 postage from Bank Street College of Education, 610 West 112th Street, New York, NY 10025, tel: (212) 663-7200. The next in the series of cassettes will be on nutrition.

Conference Call:

February, 1987

February 20-22: "Vulnerable Infants, Stressed Families: Challenges for Research and Practice" is the title of 3-day regional training institute sponsored by the *National Center for Clinical Infant Programs, five divisions and departments of the State of California, and five state or national professional organizations.* The multidisciplinary institute will focus special attention on: 1) infants and toddlers in child care; 2) multicultural issues in serving young children and families; 3) supporting the development of disabled and high risk infants and toddlers; and 4) young children of substance abusing parents. Plenary speakers include C. Arden Miller, Stanley Greenspan, Sally Provence, Bernice Weissbourd, Kathryn Barnard, Geneva Woodruff, Jeree Pawl, Alan Fleischman, Diane Bricker, Dante Cicchetti, Arnold Sameroff, Merle McPhereson, Edward Zigler, and the Honorable George Miller.

For information contact Infant Conference '87, Exceptional Children's Foundation, 2225 W. Adams Boulevard, Los Angeles, CA 90018, tel: (213) 734-6132.

March, 1987

March 6-7: *The Blind Children's Center* and the *Children's Hospital of Los Angeles* will present a symposium on "The Visually Impaired Child: Medical, Development and Ethical Issues" in Los Angeles. T. Berry Brazelton will be the keynote speaker. General sessions will address physicians' and parents' perspectives on diagnosis of visual loss in infancy; medical and functional assessment of visual acuity in infancy; ethical issues regarding the imperiled newborn; and other topics. Contact Patsy Rahn, The Blind Children's Center, 4120 Marathon Street, P.O. Box 2159, Los Angeles, CA 90029-0159, tel: (213) 664-2153.

March 7: *Boston University School of Medicine, Wheelock College* and the *Federation for Children with Special Needs* will present a course on "Children with Disabilities: Parents and Professionals Working Together" in Needham, Massachusetts, directed by Barry Zuckerman. Contact the Department of Continuing Medical Education, Boston University School of Medicine, 80 E. Concord Street, Boston, MA 02118, tel: (617) 638-4605.

March 13-14: "People, Skills and Money: Building Comprehensive Community Services for Infants, Toddlers and Their Families" will be a two-day regional; conference sponsored by the *National Center for Clinical Infant Programs* and *Schneider Children's Hospital of the Long Island Jewish Medical Center.* Plenary addresses, case presentations, panels and special interest sessions will examine ways to mobilize the resources essential to creating and maintaining high quality services for normal, disabled and at-risk infants, toddlers and their familes. Faculty members include Edward Zigler, Alfred Kahn, Michael Lewis, G. Gordon Williamson, Sally Provence, Vince Hutchins, Catherine Rowan, Jane Dustan, Mareassa Isaacs, Stephen Herman, Nancy Balaban, Patricia Nachman, Irene Hassett, Annette Axtmann, and Philip Lanzkowsky. For information contact Ann Boehme, Continuing Education Coordinator, Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, New York 11042, tel: (718) 470-8650.

March 25-29: The *American Orthopsychiatric Association* will hold its 64th Annual Meeting in Washington, DC with the theme "Toward Empowerment of Families: Strategies for Change." A one-day institute on infant and early childhood prevention will be given by Robert Nover. Other meeting sessions will address child development and child care; the family resource movement; chronically ill infants and children; and mother-infant rooming in on a psychiatric unit. For further information write or call ORTHO, 19 W. 44th Street, Suite 1616, New York, NY 10036, tel: (212) 354-5770.

March 17-20: *The Child Welfare League of America* will hold its national conference, "Speak Out for Children," in Washington, DC. Speakers will include Michael Dukakis, Jean Elder, Lou Harris and Bob Greenstein. Workshops will discuss day care, family support services, comprehensive agency models, emotional battering of children and welfare reform. Contact CWLA, 400 First Street, NW, Washington, DC 20001.

March 30-31: The *U.S. Department of Labor*, in cooperation with the *AFL-CIO* and the *National Association of Manufacturers*, will sponsor a conference on "Work and Family: Seeking a New Balance." Alternative work patterns, parental leave, child and elder care and flexible benefits will be among the topics discussed. Speakers will include William Brock, Thomas Donahue, Stanley Gault and Colleen Dewhurst. Contact Patricia Presley, Cumberland Conference Coordinators, P.O. Box 398, Cumberland, MD 21502, tel: (310) 777-8701.

April, 1987

April 2-3: *The E. John Gavras Center* will sponsor its seventh Focus on Infants conference in Auburn, NY, featuring presentations on the assessment of sensory processing in infants and toddlers, a premature infant development scale, and fathers' interactions with babies. Michael Yogman, Georgia De Gangi and Judi Bierman will be among the faculty. Contact Focus on Infants, E. John Gavras Center, 182 North Street, Auburn, NY 13201, tel: (315) 255-2746.

April 3-4: *The Division of Developmental and Behavioral Pediatrics of the Boston University School of Medicine* will sponsor a course on "Behavioral Pediatrics: Clinical Problems in Primary Care" in Boston, Massachusetts under the direction of Barry Zuckerman. Topics to be discussed include malnutrition in early life; feeding and eating problems; the impact of maternal depression on children; child care practices in other cultures; and otitis media and development. Contact Continuing Medical Education, Boston University School of Medicine, 80 East Concord Street, Boston, MA 02118, tel: (617) 638-4605.

May, 1987

May 24-29: *The Fourth International Conference of Toy Libraries* will take place in Toronto, Ontario, Canada and address the theme "Sharing Through Play." Play and parenting, play in rural and urban environments, and play and the special child are among issues to be discussed. Contact Conference Office, Suite 5-105, Ontario Institute for Studies in Education, 252 Bloor Street, W., Toronto, Ontario, Canada, M5S 1V6.

June, 1987

June 22-26: *Erikson Institute for Advanced Study in Child Development* will present its second annual intensive course on child abuse prevention in Chicago, taught by James Garbarino. For further information contact Eva Duncan, Erikson Institute, 25 West Chicago Avenue, Chicago IL 60610, tel: (312) 280-7302.

August, 1987

August 13-15: *The Pediatric Section of the Hungarian Society for the Rehabilitation of the Disabled* will sponsor a symposium on Age-Dependent Neurorehabilitation prior to the Second World Congress on Neuroscience in Budapest, Hungary. Metholodogy in secondary prevention and rehabilitation of cerebral palsy, malformations of the CNS, and spinal cord lesions will be among the main topics. Contact Bernard Z. Karmel, Ph.D. Department of Pediatrics, Anbg 1780, Mt. Sinai Medical Center, 98th Street and Madison Avenue, New York, NY 10029, tel: (212) 650-5447 or 650-6186.

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INFANTS CAN'T WAIT: The Numbers
(see page 14)

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NCCIP
733 15th St., N.W., Ste. 912
Washington, D.C. 20005

Please send me ________ copies of *Infants Can't Wait* and Infants Can't Wait: The Numbers at $5/set plus $1.50/set for postage.
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Basic Criteria for Tracking
At-Risk Infants and Toddlers
(see page 14)

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Bulletin of the
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Infant-Parent Psychotherapy With an Autistic Toddler

by
Barbara Kalmanson, M.A. and Judith H. Pekarsky, Ph.D.
Infant-Parent Program
Department of Psychiatry
San Francisco General Hospital
University of California, San Francisco

The case presented here describes the treatment of Jonah, an autistic child who came to us as a toddler and whom we followed to the age of 5. The work took place through the Infant-Parent Program, an Infant Mental Health Program, begun in 1979 by Selma Fraiberg, and modeled after her innovative work at the University of Michigan. The Infant-Parent Program is part of the Department of Psychiatry at the University of California, San Francisco, and is based at San Francisco General Hospital.

The approach to the treatment of Jonah and his parents was an outgrowth of the method of infant-parent psychotherapy described by Fraiberg and her colleagues (Fraiberg, 1980; Pawl and Pekarsky, 1983; Lieberman, 1983). In line with this model, the primary goal of the work was to develop a mutually satisfying relationship between the parents and their child. This involved careful attention to the parents' feelings and a focus by both therapists and parents on the child's affective experience and needs.

Assessment

Jonah's family was referred to the Infant-Parent Program by his pediatrician when Jonah was 18 months old. He had been having staring spells for the last 2 months and often seemed extremely aloof, preoccupied, and difficult to contact. There were episodes of such inaccessibility that neither his mother's shaking him nor passing her hand in front of his eyes brought any response. In the previous 2 months Jonah had stopped using all but 3 or 4 of the 15 words he had acquired.

In the course of our assessment, it became evident that both of Jonah's parents were in crisis. They were reacting to the difficulties in making a connection with Jonah and felt bewildered, rejected, and helpless. They were continuing to reach out to their son, but with a sense of increased foreboding about their ability to get a response.

Barbara Young

© Infant Mental Health Journal

An expanded version of this article will appear in the Fall 1987 issue (Volume 8, Number 3) of the Infant Mental Health Journal. The Journal is published quarterly. Subscription information is available from Hiram Fitzgerald, Department of Psychology, Michigan State University, East Lansing, MI 48824-1117.

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National Center for Clinical Infant Programs *733 15th St., N.W., Suite 912, Washington, D.C. 20005* *(202) 347-0308*

As the assessment proceeded, Jonah's developmental history gradually emerged. Jonah was the Burke's only child, the product of an uncomplicated pregnancy and delivery. From birth, Jonah was extremely irritable and unusually sensitive to light and sound. He had difficulty with state transitions. He cried for long periods and was very difficult to console.

Jonah's major developmental milestones were all within normal limits although no truly social smile had ever developed. Following breast feeding, he insisted on feeding himself and refused any lumpy or rough-textured foods. Jonah also showed an intolerance for shifts and changes in his routine or environment.

At the time of the assessment, Jonah's affective and social functioning, his sensory integration, and his cognitive abilities were atypical. He was able to remain solitary and unrelated for long periods of time, never approaching his parents for reassurance, for comforting at times of distress, or to share moments of pleasure. Jonah never allowed mutual eye contact or cuddling, and squirmed in distress in his mother's lap. His typical method of making contact was to direct the other person's hand like a tool in order to reach an object or facilitate its use. Jonah's slight and fleeting smiles were evoked by his own activities with toys, and the pleasure was experienced privately.

There was evidence throughout the assessment that Jonah had difficulties with sensory modulation and perceptual integration. He seemed easily overwhelmed by sensory input and gave evidence of unusual sensitivity to a variety of visual, auditory, olfactory, and tactile stimuli. When he experienced stimuli as too intense, he was driven to complete withdrawal and preoccupation with self-stimulatory activity.

Jonah's cognitive functioning was markedly uneven. He showed serious difficulties in language - with an unusual mixture of infantile vocalizations, squeals and squeaks, and 2 or 3 words not used communicatively. Jonah's comprehension of language appeared limited to the recognition of a few key words and invariant phrases paired with a consistent gesture or visual cue. In the area of symbolic functioning, he showed little evidence of early imitative abilities, object permanence was as yet incompletely established, and he had no representational play. In contrast, Jonah demonstrated precocious abilities in visual-motor performance.

The possibility that Jonah's disturbance resulted from a seizure disorder or hearing impairment was investigated and ruled out during the assessment.

When our assessment was completed, it was clear that Jonah met all the criteria for the diagnosis of infantile autism delineated in the American Psychiatric Association's Diagnostic and Statistical Manual III (1980). The onset of his difficulties occurred before 30 months: he showed a pervasive lack of responsiveness to others; he had gross deficits in language; and he was resistant to change. He also showed some of the "associated features" of this diagnosis: he was over-responsive to sensory stimuli, and he demonstrated marked variability in his intellectual functioning with deficits in verbalization and symbolic thought and excellent performance on visual-spatial tasks. Jonah's intellectual strengths identified him as among the better functioning children with this diagnosis and suggested a good long-term prognosis. We therefore viewed him as in a good position to make use of our interventions.

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DEVELOPMENTAL SIGNS OF AUTISM IN THE FIRST THREE YEARS OF LIFE

Autism is a pervasive developmental disorder with onset before 30 months. There is increasing agreement that the syndrome is actually present from birth. Typically, however, it is not identified until the child's failure to develop communicative language is apparent. Recent research on infant development and infant-parent interaction provides information that may allow earlier identification of the disorder.

Below are some developmental signs of autism which professionals might keep in mind. It is important to be aware that no single atypical behavior is indicative of autism. The disorder is defined by a pattern of behavior that includes difficulties with social relationships, communication, perceptual integration, and adaptability to changes in the environment.

Signs in Infancy

MOTOR	PERCEPTUAL	SOCIAL-EMOTIONAL	LANGUAGE	MENTAL REPRESENTATION
Inactive • flaccid muscle tone • rarely cries or *Irritable* • inconsolable • only soothed when in constant motion • limp or • rigid when held • arches away from close physical contact *May have given up or lost an acquired skill*	*Unusually sensitive to sensory stimuli* Auditory: • appears deaf to voice but jolts or panics at environmental sounds Tactile: • refuses food with rough texture • adverse reaction to wool fabrics—prefers smooth surfaces Visual: • sensitive to light • may panic at change in illumination • preoccupied with observing own hand and finger movements	*Unresponsive* • no social smile • avoidance of eye contact when held • fleeting eye contact at a distance • lack of anticipatory response to being picked up • seems not to like being held • seems content left alone • fails visually to follow coming and going of primary caregiver • doesn't play peek-a-boo or patty-cake or wave bye-bye • fails to show normal 8-month stranger anxiety *Fails to form strong personal attachments*	*Delayed or absent coo and/or expressive vocalization* *Failure to imitate words, sounds* *Little communicative use of gesture* *Speech retarded or shows precocious advances followed by failure to use previously learned words*	*Decreased visual pursuit of objects or people* *Object permanence develops slowly or stops at stage 2 or 3 (secondary circular reactions)*

Signs in Second and Third Years

MOTOR	PERCEPTUAL	SOCIAL-EMOTIONAL	LANGUAGE	MENTAL REPRESENTATION
Toe-walking *Rocking* *Head-banging* *Whirling without dizziness* *Perseverative movements*	*Withdraws from environmental stimulation* *Engages in self-stimulation* *Preoccupied with spinning objects* *Suddenly ceases activity and stares into space, often with hyperextension of neck*	*Moves adult's hand like a tool* *Insists on sameness and ritualizes routines*	*Echolalia* *Delayed echolalia unrelated to social context* *Pronoun reversals* *Voice atonal, hollow, arhythmic*	*No representational play* *Little appropriate use of toys* *Preoccupied with impersonal invariant information (e.g. television commercials)*

First Year of Treatment

To meet the needs of all the family members, our usual model (Fraiberg, 1980) of infant-parent psychotherapy was modified. Two therapists worked simultaneously in the family's home, meeting once a week for sessions usually lasting an hour and a half. This arrangement allowed one therapist to provide Jonah with the undivided attention he required to become engaged in the social world, while the other therapist was available to respond to Mr. and Mrs. Burke. The actual work with the child and his parents continually intersected and coalesced as Jonah and Mr. and Mrs. Burke attended to and interacted with one another, and the therapists.

Mr. and Mrs. Burke

The treatment in this case included the most devoted and sensitive collaborators - Jonah's parents. They were in the prime position to help Jonah develop into a social and communicating being, since they were with their son continuously. The work with the Burkes was aimed at removing any internal barriers to rewarding interaction with Jonah. This involved exploring and offering continuous support around their complicated feelings about Jonah and themselves as parents—particularly their sense of unimportance to him, their frustration and anger, and their feelings of responsibility and guilt. Along with the support provided, efforts were made to point out when there were signs in the sessions of Jonah's attachment to his parents, and evidence in his behavior that he was registering and responding to their feelings. This allowed the Burkes to risk more attempts to contact their son.

Another major issue in our early work involved exploring the ways in which the Burkes' reactive feelings had influenced their relationship with Jonah. They reported that life was so difficult with him, they were nearly ready to give up. Through experience they had learned not to disturb Jonah, and they had become somewhat hesitant and tentative in trying to contact him. As they recognized this dynamic and its consequences, and as they began to glimpse some possibilities for interatction with their son, they became more able to reach out to Jonah and engage him.

Another aspect of the treatment involved investigating and revising the Burkes' many misconceptions about the meaning of Jonah's perplexing behavior. They came to understand that Jonah was not unwilling to relate to them, but was engaged in an internal struggle to manage stimulation. This understanding enabled the parents to empathize with their son and wholeheartedly engage in efforts to help him. The Burkes were eager participants in all of this work, and they rapidly became the skillful extenders of Jonah's treatment. This does not mean that they became therapists; rather they were able to sustain natural parental feelings and functions while providing their son with the special kinds of interaction and structure which he needed.

Jonah

During the first year of treatment our work with Jonah was primarily focused on encouraging reciprocal social relationships and developing mental representation and language. In order to make him available for relationships we also needed to learn how to manage the environment for him by modulating the sensory stimuli that caused him to withdraw.

Throughout the sessions with the family, I[*] attempted to follow Jonah's lead continuously and use every opportunity to gratify his wishes and draw his attention to the rewards of interaction. In my search for ways to engage Jonah and maintain his interest in social interaction, I experimented with various dimensions of environmental stimuli—including vocal inflection, and speed and intensity of voice, integrated with tactile stimulation and an optimal physical distance for maintaining eye contact.

I remained constantly available to Jonah throughout each session. Whenever I had the opportunity, I encouraged him to use me to open a latch, reach an object, or hand him a toy. I always handed him the object in our mutual line of vision so that he had to notice my face and hands simultaneously as I gratified him. He could not overlook the fact that this tool-like hand was part of the person who was responding to his wishes. Often, this entailed lying on the floor next to him, or scurrying about the apartment in tandem.

Over the course of many sessions, we evolved a repertoire for exploring the kitchen cupboards which made Jonah dependent on me for help. He needed me to lift him onto the counter top and to secure his mobility from one counter to the next. This exploration had other advantages as well. It put us precisely at eye-to-eye level, facilitating eye contact. Jonah's pleasure in his access to previously inaccessible territory allowed me to encourage small moves toward exploration without interfering with his familiar ritualized routines. I was also able to interpret to the Burkes that his interest in the kitchen represented an interest in them since they were avid cooks. Over many weeks, Jonah's exploration developed from a perseverative opening and closing of the cupboard doors and opening and closing of spice jars, to an interest in the smell of the spices, and eventually in tasting some unfamiliar foods in the cupboard. Because of his previous aversion to crunchy foods, his mother was quite surprised one day to see him nibbling at raw noodles. Gradually, Jonah began to try these new tastes during meals.

The curriculum in the cupboards gradually led us to naming objects, pouring beans and popcorn from one size container to another, water play in the sink (which included learning to undress and dress) and finally to the beginnings of representational play—pretend cooking with playdough. Pretend cooking became a favorite pastime for Jonah. His interest in cooking

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[*] The primary therapist for Jonah was Barbara Kalmanson. The primary therapist for Mr. and Mrs. Burke was Judith Pekarsky.

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reinforced his parents' gradually developing awareness of their importance to him, and a recognition of his beginning identification with their involvement in cooking. Food preparation became the arena for family activity: the Burkes now included Jonah in all their baking, and even prepared home-made playdough.

Another of the reciprocal activities Jonah and I developed grew out of his parents' concern about some ritualistic behaviors that irritated and exhausted them. The most frustrating of these was an opening and closing of doors which rapidly disintegrated into frenzied banging. This seemed to be a rough experimental attempt to find out where things were when behind a barrier. Once we discovered this explanation for the behavior and discussed with Jonah's parents his attempts to develop object permanence, we were able to transform this ritual. We turned it into a social game that would satisfy Jonah's quest for object permanence, promote his use of people as help-mates in the learning process, and offer relief and an active role to his parents. We substituted a large box that Jonah could disappear into and reappear from.

Within a week, the box had become a focus of social activity between Jonah and Mr. Burke. Jonah's scurrying in and out of the box included opportunities for mutual gaze, vocal greetings, social smiles, and physical contact. On occasion, Mr. Burke's pleasure in this interaction and his wish for demonstrations of his importance to his son propelled him to follow his own desire for more intimate contact. Jonah's response was to arch his back, pull away, and turn his head from side to side, escaping his father's attempts to embrace. With our support and guidance, Mr. Burke was able to understand that Jonah's avoidant behavior was not a rejection of his father but an effort to protect himself from overwhelming sensory stimulation. Such explanations helped Mr. Burke endure these rebuffs and carry on the game with the intensity of contact Jonah could manage. As a result, Jonah was able and willing to maintain the contact with his father. These shifts interrupted the well-established cycle in which Jonah retreated when overstimulated and his parents gave up in despair.

As the reciprocal routines around the box became a comfortable part of daily play, the frenzied quality of Jonah's behavior disappeared: with his parents' warm approval,, he had no need to fight their prohibitions with ritualistic insistence. From our point of view, the box set an ideal stage for social play. The game gave Jonah mastery over disappearing objects, and a contingently responsive interaction complete with verbalizations and eye contact. This experience always led us to look for the meaning in Jonah's sometimes apparently senseless behavior, and to attempt to transform his rituals into socially playful interactions that addressed the developmental task he was, however primitively, attempting to master.

After six months of treatment, Jonah had developed an interest in people. He attended to social interaction and showed pleasure in his parents' and the therapists' involvement with him, as long as we mediated the environmental stimuli, were attuned to his interests, and joined his activity.

At this point, we were able to focus more intensely on interpersonal communication. From the beginning, I had drawn his attention to speech by minimizing the number of words directed to him, slowing the pace of speech, and exaggerating inflection and facial expression. I provided an extremely simplified, slow-paced, repetitive monologue describing everything he was doing, as well as everything his parents and I were doing to interest him in relating. Following continuous observation and discussion during our sessions, the Burkes began adopting all of these approaches to interaction, adapting them to their own interpersonal style. Jonah began imitating sounds, single words, and phrases from bits of conversation as his eye contact improved and as he was encouraged to imitate words that verbalized his wishes.

Jonah's advances in the development of symbolic thought and verbal expression, and his investment in relationships led to a change in the treatment. The focus of the work with him shifted from developing the cognitive and affective components of human relatedness to understanding Jonah's affective experiences.

Second and Third Years of Treatment

Treatment with this family continued for 3½ years. After the first year, our work with Jonah centered on events in his family and the typical concerns of a preschooler. Jonah did show residual autistic characteristics in language, symbolic thought, and insistence on sameness. These were addressed through subtle interventions embedded in the playful interactions between Ms. Kalmanson and Jonah. The work with the parents during this period supported their empathy and practical efforts on Jonah's behalf. It also extended to their handling of emerging age-appropriate self-assertion and aggression. By the end of treatment, both parents appeared thoroughly pleased with their son and their relationships with him. They enjoyed him, were proud of his achievements and personality, and felt like generally effective and well-loved parents.

At the time of termination, around Jonah's fifth birthday, the only remnants of his former autistic state appeared in some concretization of abstract concepts and less flexibility in his expressive language than is usually available to a bright 5 year old. These did not prevent him from acceptance at a kindergarten in an excellent private school. Jonah's intellectual abilities were above average, as measured by the Wechsler Preschool and Primary Scales of Intelligence (WPPSI). Socially, he was a very engaging, related little boy, with a fine sense of reciprocity in interactions. He had a full and sophisticated range of affective expression, and readily empathized with the experiences of those around him.

Several months before the treatment ended, Jonah summarized his own understanding of the metamorphosis that had taken place. Recalling a time when he was much younger and unable to make his wants known through language, Jonah wrapped himself up in a blanket and explained that he was in a cocoon. He then depicted his emergence from this state by rising out of the blanket, arms outstretched, with an elated expression on his face. He exclaimed, "Now I'm a butterfly!"

Discussion

The outcome of this case was especially successful. Although some autistic children develop equally sophisticated cognitive abilities, they generally continue to show affective and social peculiarities. It is highly unusual for an autistic child to develop and express a rich and varied emotional life, and to respond to othes with empathy as Jonah did. This seemed to be a direct result of the treatment's focus on Jonah's affective experience and needs, and on his parents' ability to empathize with and respond to these.

A set of factors in the family enabled the treatment to proceed so successfully: Jonah's age at the beginning of treatment, his cognitive strengths, and the Burkes' ability to use and extend the treatment. The fact that contact began when Jonah was only 18 months old allowed the work to capitalize on the plasticity of the earliest years. Jonah's age also meant that his cognitive and affective delays and distortions had not yet grown to irremediable proportions. He still had relatively little catching up to do. Jonah's developmental strengths, apparent in the earliest contacts, bespoke a constitutional intactness which enabled him to make good use of intervention.

Finally, Jonah's parents were central to his recovery. Mr. and Mrs. Burke were able to develop and sustain an exceptionally sturdy therapeutic alliance on behalf of their son. They were willing to engage in painful self-exploration and were capable of setting their own needs aside in an effort to provide extraordinary care for Jonah. The Burkes were steadfast in their commitment, patient in the process of improvement, and creative in the extension of the treatment into their daily lives.

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Parent Training with Young Autistic Children: A Report on the LEAP Model

by
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For five years now we have operated a comprehensive early intervention program for autistic and normally developing children. This program is known as LEAP, Learning Experiences... An Alternative Program for Preschoolers and Parents. LEAP Preschool is a 12-month per year, three hour per day program that is a joint effort between the Department of Psychiatry, University of Pittsburgh, the National Institute of Mental Health, U.S. Department of Education, and the Pittsburgh Public Schools. LEAP is located at Mifflin Elementary School, Pittsburgh, Pennsylvania.

Special features of the model include:

a) A comprehensive one-week assessment for autistic children that results in individualized programming for 24 hour intervention;
b) a curriculum planning process that results in lessons that are applicable to groups of children who may vary from 12 to 72 months in developmental functioning;
c) a systematic method for training normally developing children to intervene successfully on the social skills, language skills and class deportment of their autistic peers;
d) a modularized approach to parent training in which the learning of specific teaching skills is evaluated at LEAP, in the home, and in community settings;
e) a systematic plan for the transition of handicapped children to regular class settings; and,
f) the use of comparison group and multiple baseline designs to document the effects of specific program components on participants.

Over 75% of LEAP's graduates are making satisfactory progress in regular education settings, with several children now enrolled in 2nd grade. Extensive evaluations of child outcomes have been reported in Hoyson, Jamieson, & Strain, 1984; Strain, Hoyson, & Jamieson, 1985; and Strain, Jamieson, & Hoyson, 1986.

Our goal in this report is to highlight, through a case example the content and typical course of parent involvement at LEAP. A brief overview of the parent component provides an introduction.

Overview of Parent Component

Families with autistic children are involved with the total educational program (i.e., classroom program and parent training program) for a time period ranging from one to three years. Parents' participation in the training program is a requirement for enrollment of their child within the classroom program. Consequently, the parents who have participated in our training program represent highly motivated persons who have made a commitment to participate in extensive training for a period of one to three years.

Our parent training program represents a three-phase model of training that is designed to program systematically for generalization and maintenance of parent and child treatment gains. Phase I of the program represents the more intensive part of training; the parent is taught the basic principles of behavior modification and receives direct training in skill implementation across three different instructional settings (i.e., school, home, and/or community settings). For the interested reader, the following resource materials on principles of behavior modification are recommended: Patterson, G. (1976). *Living with Children.* Champaign, IL: Research Press and Becker, W. (1971). *Parents Are Teachers.* Champaign, IL: Research Press. Direct observational data are collected across all three instructional settings. During this phase the parent trainer is responsible for the development of all intervention programs. In Phase II, a consultation model of parent training is utilized; intervention programs for three additional instructional settings (i.e., home and/or community) are developed jointly by the parent and parent trainer. Parent-collected data are utilized to evaluate daily changes in the child's behavior in the home and/or community. Direct observational data on parent and child target behaviors are collected monthly in maintenance and generalization settings. The focus of Phase III is on developing independent parenting skills. During this phase, the parent is the primary person responsible for writing intervention programs for the home and/or community environments. The parent meets with the parent trainer on a once-a-month basis for the purpose of reviewing parent-implemented programs. Monthly home and/or community observations are again conducted for the purpose of assessing maintenance and generalization. By the end of Phase III, which represents termination from the preschool program, approximately 10 behavioral intervention programs will have been completed by the parent, the later ones developed and implemented independently. Once the family leaves the preschool program, follow-up observations are conducted in the home and school environment to assess maintenance of treatment gains following termination of direct service.

Parent target behaviors are divided into two generic skill categories: a) knowledge of basic principles of behavior management and programming, and b) demonstration of specific skill implementation. An overview of the first skill category will be provided next; skill implementation is illustrated by the case report.

The LEAP Parent Training Curriculum teaches knowledge of basic principles of behavior management and behavioral programming. The curriculum is divided into two components: a generic skills section and an optional skills training section. The generic skills section of the curriculum consists of 10 skill modules, taught to all parents, and designed for either individual or group parent training.

Each module includes a curriculum guide, parent activity sheets, review questions, and a parent review handout. Criterion for successful completion is 80% correct performance on the review questions. The specific skill areas focused on in the generic skills section include:

MODULE 1 - Identifying and Defining Behavior
MODULE 2 - Analyzing Behavior
MODULE 3 - Observing and Defining Behavior
MODULE 4 - Introduction to Positive Reinforcement
MODULE 5 - How and When to Use Positive Reinforcement
MODULE 6 - Structuring the Environment to Prevent Misbehavior
MODULE 7 - How to Weaken Misbehavior
MODULE 8 - Teaching New Behaviors: Task Analysis, Shaping, and Chaining
MODULE 9 - Teaching New Behaviors: Assistance, Correction, and Fading
MODULE 10 - Developing and Evaluating Behavior Change Program

The optional skills training includes six procedures for decreasing inappropriate child behaviors. These procedures are taught to individual parents in the event that the least restrictive procedures for decreasing inappropriate behaviors that are presented in the generic skills section (e.g., extinction, differential reinforcement of other behaviors, interruption and redirection) prove to be ineffective in reducing problem child behaviors.

These optional modules include a parent handout, which outlines the intervention procedure in a step-by-step format, as well as instructions for the parent trainer. These modules deal with compliance training, time-out, token economies, over-correction, visual screening, and hand-down restraint.

It should be noted that, although compliance training is listed as an optional teaching module, the majority of parents are taught this procedure during Phase I of parent training. It has been listed as an optional module, however, since a few children who have been enrolled in our program demonstrated high levels of compliant behavior, but very low levels of appropriate behavior not related to child compliance. For these children, the focus of training is on increasing other appropriate behaviors (e.g., toy use, verbalizations).

Case Study

The Thompson family was referred to LEAP after being seen at a child development unit at a large children's hospital. Referral information indicated that the Thompson's only child, Matt, who was 28 months old at the time, was the product of a normal pregnancy and delivery.

Matt's developmental milestones were within normal limits until approximately 15 months of age. At that time, the Thompsons expressed their concern to their pediatrician that Matt was not talking. Over the course of the next year Matt's behavior regressed considerably. At the time of referral to LEAP, the results of psychological and educational evaluation placed his language ability at 10 months, social behavior at 6 months, overall cognitive skills at 12 months, and motor development at 24 months. Matt was also reported to tantrum for 30 to 60 minutes at a time and engage in a variety of self stimulatory behavior. He did not play with children his age.

Selecting Target Behaviors

After Matt and his parents completed a one-week assessment period at LEAP, the staff and the Thompsons met to complete an initial plan of intervention for Matt. An overview of their plan is presented in Figure 1. As indicated, the Thompsons identified a number of child behaviors to be increased and decreased across school, home and community settings. Based upon the staff's preliminary analysis of conditions that contributed to specific behavior problems, a tentative list of interventions to be applied was formulated. As with all families at LEAP, the initial selection of child target behavior was dictated by the most urgent concerns of the parents.

Phase I Training

During Phase I of Parent Training, Mrs. Thompson attended two one-and-a-half-hour training sessions per week in the school environment. Activities conducted during this time period included initial assessment of her skill level, presentation of the curriculum modules, and structured play training sessions.

The presentation of the curriculum modules began during the second week of Parent Training. Typically, only one curriculum module was presented each week. Decisions regarding the sequence of presentation of these modules was left to the discretion of the parent trainer. (Some alteration in the sequence of presentation of curriculum modules may occur if the parent trainer wishes to match up the skills being taught in the structured play session to the skill concepts presented in the curriculum.) The information contained within each curriculum module can generally be presented in one or two weekly training sessions. The exact rate of presentation of curriculum content, however, is individually determined for each parent. The criterion for successful completion of a curriculum module is 80% correct performance on the review question section of the module. Mrs. Thompson took 13 weeks to complete 10 core modules.

During the same time period, structured play sessions

FIGURE 1

Parent and Child Target Behavior Needs Assessment

Child's Name: Matt Parent's Name: Thompson Date: 9-9-84

Setting	Appropriate Behaviors to Be Increased	Procedures to Increase Appropriate Behaviors	Inappropriate Behaviors to Be Decreased	Procedures to Decrease Inappropriate Behaviors
SCHOOL: PLAY	1. Compliance	1. Praise for compliance	1. Noncompliance	1. Physical prompting for noncompliance
	2. Appropriate use of toys	2. Praise for appropriate use of toys; modeling of appropriate use of toys, instructions to use toy in a specific manner	2. Visually fixating on toys	2. Interruption and redirection
	3. Appropriate speech	3. Praise for appropriate speech; attending statements describing the child's actions; modeling of appropriate speech; requiring the child to say the name of the toy before receiving it	3. Throwing toys	3. Interruption and redirection
	4. Quiet play	4. Praise for quiet play	4. Stereotypic humming	4. Visual screening
			5. Tantrums	5. Extinction
HOME: MAINTENANCE	1. Compliance	1. Praise for compliance	1. Noncompliance	1. Physical prompting for noncompliance.
	2. Sitting in chair	2. Praise for appropriate sitting. Placement of the child's chair in close proximity to parent's chair	2. Getting out of chair	2. Physical repositioning of the child back in the chair with rule clarification
	3. Appropriate speech	3. Praise for appropriate speech; attending statements describing the child's actions; modeling of appropriate speech, requiring the child to say the name of the desired food item before receiving it	3. Stereotypic humming	3. Visual screening
	4. Quiet eating	4. Praise for quiet eating	4. Tantrums	4. Extinction
	5. Appropriate use of cup	5. Praise for appropriate drinking	5. Throwing of cup or dumping milk	5. Response cost: removal of cup for duration of meal
COMMUNITY: GROCERY SHOPPING	1. Compliance	1. Praise for compliance	1. Noncompliance	1. Physical prompting for noncompliance
	2. Sitting in grocery cart seat	2. Praise for appropriate sitting. Parent to maintain within a close proximity to grocery cart	2. Getting out of cart seat	2. Physical positioning of the child back into the cart seat with rule clarification
	3. Hands inside the cart	3. Praise for hands inside cart. Parent to maintain cart in middle of aisle, with food items on shelf not within child's reach	3. Grabbing food items off shelves	3. Interruption and redirection
	4. Quiet while sitting in grocery cart	4. Praise for quiet sitting	4. Stereotypic humming	4. Visual screening
			5. Tantrums	5. Extinction

in the school environment were utilized to teach parent target behavior. One to two structured play sessions were conducted each week. One play session was conducted each week if community training was scheduled during classroom programming; otherwise, two play sessions were conducted each week. The structure of the play session was as follows: five predetermined toys were selected for Matt and the toys were located on a table approximately eight feet away from the designated play area. The sequence of presentation of the toys was reviewed with Mrs. Thompson prior to the beginning of the training session. During the 15-minute training session, she was cued every three minutes to have Matt switch toys. The session is thus structured to facilitate the observation of child compliance and appropriate behavior.

The parent trainer's interventions during these structured play settings included:

a. A five-minute verbal review session with the parent, for the purpose of identifying the specific targeted intervention procedures that the parent was to practice during the session;
b. A five-minute modeling session, in which the parent trainer modeled the procedures with the child during play activities;
c. A 15-minute parent practice session, in which the parent directed the child to play with each designated toy for a three-minute time period; and,
d. A five-minute session, in which the parent trainer provided verbal feedback to the parent on correct and incorrect usage of the intervention procedures.

During the 15-minute parent practice session, the parent trainer initially cued Mrs. Thompson, if necessary, to utilize a specific behavioral procedure. Praise was also given for observed demonstration of the correct usage of a procedure. Cue and praise statements were recorded on a direct observational data collection recording form. Throughout the practice sessions, cues and praise statements were systematically faded out, so that the last three observed parent practice sessions were conducted with no cues or praise statements from the parent trainer. Examples of cues included statements such as "Physically prompt to sit down," or "Turn your head away and ignore the tantrum." Example of praise statements included, "You're doing a nice job of not repeating your commands," or "You did that time-out procedure perfectly."

During Phase I of Parent Training, weekly home visits were scheduled with Mrs. Thompson. Specific child problem target behaviors were observed in either one or two observational settings. Intervention began in the home environment: a) following the initiation of intervention in the school environment, and b) after three baseline observational sessions had been conducted in the home environment. The intervention procedures that were utilized during home training were similar to those utilized during school training. After the home behavioral intervention plan had been reviewed with Mrs. Thompson, intervention procedures for each home visit included:

a. A five-minute verbal review session with the parent, for the purpose of identifying the specific targeted intervention procedures that the parent was to practice during the session;
b. A five-minute modeling session, in which the parent trainer modeled the procedures with Matt during the routine home activity, or a role play session with Mrs. Thompson where the parent trainer played the role of the child;
c. A 15-minute parent practice session in which Mrs. Thompson was observed while implementing the targeted behavioral procedures; and,
d. A five-minute session, in which the parent trainer provided verbal feedback to Mrs. Thompson on correct and incorrect usage of the intervention procedures.

During the 15-minute parent practice session, parent trainer cues and praise statements were again utilized initially. Cues and praise statements were systematically faded as described under school training.

Weekly community training sessions were conducted also during Phase I of Parent Training. Community training sessions were conducted during classroom hours, with Matt being released from classroom for one hour per week for training.

Intervention began in the community environment: a) following the initiation of intervention in the school environment, and b) after three baseline observational sessions had been conducted in the community setting. The intervention procedures that were utilized during community training were identical to those utilized during school and home training with the following exceptions:

a. The five-minute verbal review session with the parent was conducted in the school environment, prior to entering the community setting (grocery);
b. If role playing was utilized rather than in vivo modeling, the role play session was conducted in the school environment prior to entering the community setting; and,
c. The five-minute verbal feedback session with the parent was conducted after Mrs. Thompson and Matt returned to the school.

Cueing and praising procedures were utilized in the same manner as outlined for school and home training.

Direct observational data were collected by the parent trainer and an independent observer on parent and child target behaviors across all three instructional settings. A Behavior/Satisfaction Rating Scale was also completed by Mrs. Thompson for these settings.

The criteria for successful completion of Phase I included:

a. *Parent Criteria:* 80% correct performance on review questions for each of the 10 curriculum modules, and demonstration of 80% correct performance on the direct observational summary score of parent's appropriate use of behavioral procedures across all three instructional settings for five out of seven

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training sessions.

b. *Child Criteria:* Demonstration of an 80% compliance and appropriate behavior score on the direct observational data across all three instructional settings for five out of seven training sessions.

Phase II and Phase III Training

During Phase II of Parent Training, Mrs. Thompson met with the parent trainer two to four times a month for consultation on home and/or community behavior programs.

In addition, Mrs. Thompson was also scheduled for classroom training one day per week. During classroom training, the lead teacher trained Mrs. Thompson to implement behavioral intervention procedures that had been presented in parent training with a variety of other children. Mrs. Thompson at first observed instructional activities within the classroom and then began to assist with non-instructional tasks. Finally Mrs. Thompson was assigned specific instructional activities within the classroom. She received feedback from both the classroom teacher and the parent trainer.

Monthly structured "play maintenance sessions" were another feature of Phase II. Maintenance sessions were identical to the structured play sessions conducted during Phase I, but no trainer-parent interaction occurred between sessions. If Mrs. Thompson was observed to decrease her performance on any previously targeted behaviors, or if Matt's behavior was observed to be below criterion for Phase I, retraining, identical to the Phase I intervention, was instituted until criterion level performance was met. Only one retraining session occurred.

During Phase II the home training monthly home visits focused on behavior programs that had been targeted during consultation. Verbal feedback was provided to Mrs. Thompson following the observational session. If needed, in-home modeling was instituted to teach correct usage of an intervention procedure, and additional practice roleplay situations were scheduled during school consultation meetings.

Monthly community observations were scheduled either during classroom hours or at the same time as scheduled home visits, for the purpose of observing current community behavior programs that had been targeted during consultation. Once again, verbal feedback was provided to Mrs. Thompson following the observational session. If needed, in-vivo modeling was instituted to teach correct usage of an intervention procedure, and additional practice roleplay situations were scheduled during school consultation meetings.

Direct observational data were collected on parent and child target behavior during the monthly structured play maintenance sessions and the monthly home and community sessions, for the purpose of assessing maintenance and generalization of parent and child target behaviors during daily implementation of behavioral programs.

During Phase II of Parent Training, Mrs. Thompson and the parent trainer were responsible for writing three home and/or community goal plans jointly, so that Mrs. Thompson could prepare to write her own behavioral intervention goal plans during Phase III.

The criteria for successful completion of Phase II of Parent Training included the following:

a. *Parent Criteria:* Demonstration of 80% performance on the direct observational summary procedures during school, home, and/or community observation, for two out of three monthly sessions.

b. *Child Criteria:* Criterion performance for all three home and/or community behavior programs; demonstration of an 80% compliant and appropriate behavior score on the direct observational data during school, home, and community observations for two out of three monthly sessions.

During Phase III of Parent Training, Mrs. Thompson was scheduled to meet with the parent trainer once a month for the purpose of reviewing home and/or community behavior programs. In addition, she continued to work in the classroom for one day a week. Monthly structured play maintenance sessions continued until the Thompsons terminated from the preschool program. During Phase III of Parent Training, Mrs. Thompson was responsible for independently developing and implementing four home and/or community goal plans.

Overview of Outcomes

Parent training for the Thompsons had effects in three areas: direct effects on the parents, indirect effects on the parents, and indirect effects on Matt. Skill acquisition data and satisfaction ratings by parents document direct effects on parents knowledge of behavioral principles. Mrs. Thompson, like all 20 parents who have received training at LEAP, met all skill criteria in a rapid fashion. In school, home, and community sessions, she took an average of six sessions to reach criterion level performance. On a standardized instrument for assessing behavioral principles, *Knowledge of Behavioral Principles Applied to Children* (O'Dell, 1976), Mrs. Thompson achieved a score of 42% correct initially and 89% after completing the curriculum modules. Because there may not always be perfect correspondence between behavioral improvement and parents' satisfaction with outcomes, we ask parents to rate their satisfaction (or comfort) with their child's behavior during each observation session. Over the course of the Thompsons' two-year participation, ratings changed dramatically, with Mrs. Thompson reporting complete satisfaction with Matt's behavior during the final three months of treatment.

Indirect effects on parents are assessed at LEAP through three measures of individual and family functioning. All parents are administered the Beck Depression Inventory every six months. (In the case of the Thompsons, no problems were noted.) Every six months, also, parents complete the *Questionnaire on Resources and Stress* (Holroyd, 1974), which measures the parents' attitude toward the child. Both Mr. and Mrs. Thompson initially viewed Matt as a life-long dependent, as a future financial and emotional burden, and as damaging to their careers and relationship. At the end of treatment none of these attitudes prevailed. Weekly, parents complete the *Community Interaction Checklist* (Wahler, 1980), a self-report device designed to measure the insularity of the family from supportive, extra-familial community contact. Since insularity has been associated with a poor prognosis for parent-assisted therapy, we felt that the Checklist tapped a particularly important dimension of family functioning for LEAP clients. During the first 14 weeks of intervention, the Thompsons weekly scores indicated an insular pattern, with few visits made to friends and few acquaintances coming into the home. From this time forward all weekly Checklists indicated a non-insular pattern.

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Indirect effects of parent training on children are assessed by direct observation of the child's appropriate behavior and compliance with parental requests. Across all the settings for training, Matt's pre-intervention behavior was consistently unacceptable. On average, he obeyed only 10% of parental requests, and he spent better than three-fourths of each session engaged in some form of inappropriate behavior such as self-stimulation or tantrums. When his mother began to use the selected behavioral procedures, Matt's behavior gradually improved. Eventually he met criterion level in all situations. It is important to point out, however, that Mrs. Thompson often had to use her newly acquired skills for several sessions before any improvement in Matt's behavior was achieved. During the initial phases of intervention the parent trainer regularly encouraged Mrs. Thompson and assured her that slow change was often to be expected.

Currently, Matt is enrolled in first grade, after having completed a successful year in a regular kindergarten setting. All his developmental assessments place him at age level or slightly above. In the home, Mrs. Thompson continues to use the strategies she was taught at LEAP. Matt, in her words, "is our new-found son."

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Point of View:

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In early spring, perhaps at the moment you are reading this article, draft regulations for P.L. 99-457, the Education of the Handicapped Act Amendments of 1986, will be published in the *Federal Register*. These preliminary regulations will be designed to clarify the legislation enacted in October of last year which created a new discretionary program for states to address the needs of disabled and at-risk infants, toddlers and their families. Comment on the regulations regarding services for children from birth through two years and their families will be accepted for 60 days. After these comments have been analyzed by Department of Education personnel and changes have been made if deemed appropriate, final regulations will be promulgated.

We urge everyone concerned about the well-being and development of infants, toddlers and their families to study P.L. 99-457 and, if possible, the committee report; to consider the appropriateness of the proposed regulations; to weigh their implications for his or her own family, agency, community and state; and to submit comments. Since this article is being written while the regulation drafting process is still underway in the Department of Education, we are not offering our own comments here. Instead this brief essay attempts to place P.L. 99-457 in the broader context of current national initiatives on behalf of very young children and their families. The four authors, each with different professional training and experience, also suggest, from our varied perspectives, some points to consider as we study the proposed regulations. Although P.L. 99-457 affects children from birth through five, we will focus here on the implications of the law for infants and toddlers.

The context

P.L. 99-457 has been enacted at a time when children from birth to three and their families are attracting attention at many levels of policymaking. In communities across the country, grassroots family resource programs and parent-to-parent networks are striving to support parents who are coping with the ordinary stresses of contemporary childrearing as well as families whose infants and toddlers face special challenges. While some organizations are mobilizing community-based public and private resources to meet unique local needs, other groups are forming state and national coalitions to press for widespread action to establish more adequate prenatal care, parental leave guarantees, increased family support services, and greater child care options.

In response to such activities, but also out of independent recognition of the importance of the earliest years of life, a number of states are beginning to invest heavily in services for very young children and their parents. Some have already incorporated health, education and social services into coordinated systems of early intervention services for disabled, developmentally delayed and at-risk infants and toddlers. States also have been revising child care standards for very young children and are seeking to improve the training of providers. Several are mounting innovative prevention initiatives intended to reduce infant mortality and low birthweight, reduce the incidence of teen pregancy, and provide social support for young families. Some states are deeply involved in all three types of efforts designed to benefit children under three and their families; a few are seeking to integrate employment-related child care, prevention and early intervention activities at the state and local level.

> *We urge everyone concerned about the well—being and development of infants, toddlers and their families to study P.L. 99-457 carefully and to comment on the draft regulations.*

At the federal level, although appropriations remain inadequate to meet the needs of all families with young children who meet eligibility requirements, most policymakers do now acknowledge the effectiveness of existing programs such as Head Start and WIC (the Special Supplemental Food Program for Women, Infants, and Children). In addition to P.L. 99-457, the 99th Congress passed the Sixth Omnibus Budget Reconciliation Act of 1986 (P.L. 99-504), which allows states to expand Medicaid eligibility significantly to pregnant women and children up to age 5. Congress also increased the Maternal and Child Health Block Grant authorization by $75 million and designated future possibilities for earmarked funds for primary health services demonstration projects for children and community-based service network and case management services for children with special health needs.

Although comprehensive federal child care legislation is far from enactment, the 99th Congress did appropriate $1 million for scholarships to enable low-income child care employees to seek training and national certification as Child Development Associates.

Reform of the nation's welfare system is of current major concern to both federal and state policymakers, who are only too well aware of the growing numbers of young children whose early development and future productivity are likely to be compromised by a childhood lived in poverty. The daily caregiving experiences of many infants and toddlers are likely to be affected significantly by such efforts.

Increased attention, at so many levels, to the earliest years of life offers practitioners, parents, and planners new opportunities for collaboration — and new arenas for potential conflict. As we work together we must keep in mind our common goal: to provide supports that strengthen, rather than undermine, families and that are responsive to the multiple needs of infants and toddlers. As we study the broad legislative language of P.L. 99-457, we need to imagine creative ways to use its provisions to improve integrated services in our own states and communities.

P.L. 99-457's challenge to the field

The Education of the Handicapped Act Amendments of 1986 are, inevitably, a product of their time. They recognize both the central role of families in the lives of their children and the tremendous potential of early intervention to enhance the development of disabled and at-risk infants and toddlers. The amendments are testimony both to the passionate conviction of their Congressional sponsors, Lowell Weicker and Pat Williams, and to the ability of a broad range of professionals and advocates to craft (very quickly) a piece of legislation that (astonishingly quickly) could be reported out of committee, voted on by both houses of the Congress, and signed by the President.

In the words of a key committee staff member, however, "Congress doesn't know how to structure a program that is responsive to the developing infant rather than to a bureaucracy." This is the task *we* must all address. We can begin by commenting on the legislation and on the proposed federal regulations from our perspectives as parents, practitioners, researchers and administrators. At the same time we need to get involved in our state-level processes of designating or establishing a lead agency to administer services for children birth through 2 years, of choosing an advisory council, and of defining the population to be served. As we do so, we should keep in mind what we have learned over the past few decades about the developing infant and about programs that are responsive to the needs of young children.

Selected points to consider

1. It is time to move beyond complex service "systems" that require parents to assemble the puzzle pieces themselves.

P.L. 99-457 requires the development of a comprehensive service system. Let us use this opportunity to create programs that offer children and families a coherent core of basic services. These should include, at a minimum:

- child developmental/educational services;
- appropriate therapies and health services; and
- parent support.

Parents should not be required to "shop around" for discrete services — to seek, for example, a group social and language experience through the public schools; one set of therapies from a private agency; additional, separate therapies from a hospital team and parent support from yet another source. It is our professional responsibility to design programs that integrate all necessary services. We should also make every effort to work toward the provision of these services through interdisciplinary teams, whose members, including parents, work together on an ongoing basis. The provisions and regulations of P.L. 99-457 can be used to facilitate this goal.

In addition to requiring integration, early intervention services must be flexible and tied to individual family needs. Toward this end, we should use the new legislation to move existing programs to new levels of creativity. As a "one-size-fits-all" curriculum is inappropriate for children, a "one-size-fits-all" program model that offers only home visiting or only center-based group programming or only individual therapy will not meet the range of needs of families. The development of specialized components within a comprehensive early intervention program can ensure that different populations are served appropriately, with families able to decide on the level of intensity of contact they wish, and to choose from among a variety of program services and models. For example, children with multiple, severe disabilities may need developmental day care and/or respite services as part of their early intervention programs. Families of children with progressive disorders or life threatening illness should be able to receive appropriate nursing, therapeutic and social support services through, or closely coordinated with, the early intervention program. Appropriate services should remain available to the dying child and to the bereaved family. Families and infants living in environments that may be inadequate to support a young child's healthy development should be able to participate in developmentally appropriate day care services as needed, tied to specialized developmental and social services.

Lastly, we must assure that access to services is easy. If public awareness efforts are successful, many people in the community may identify young children and families appropriate for screening, assessment and services. Every community should have one place to call with referrals, and responsive people at the other end of the phone.

2. While P.L. 99-457 is administered at the federal level by the Department of Education, health services must

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be an important, integrated part of a comprehensive early intervention service system.

That P.L. 99-457 may seem to lack sufficient emphasis on health services for young children with disabilities may say more about the legislative process through which the law was drafted and passed than about the actual content — current or desired — of early intervention services. Although the medical contribution to overall service delivery may vary throughout childhood and into the adolescent years, its importance in the *first* years of life is clear. Thus, regardless of which agency is designated as the "lead agency" for children from birth through two years in a given state under P.L. 99-457, close collaboration among the health, education, and social service communities is essential.

As the professional with, often, the greatest opportunity to have ongoing contact with very young children and their families, the primary care physician or nurse must play a vital role in any strategy focused on the early identification of infants with atypical development. The initial assessment of any young child with developmental delays or difficulties requires the inclusion of a comprehensive pediatric history, a complete physical and neurodevelopmental examination, and consideration of appropriate medical diagnostic procedures. Although at times subsequent educational and therapeutic planning for some children may be relatively unaffected by the findings of a medical evaluation, such information is still important for all parents, as they seek answers to such questions as: What caused my child's problem? Is it inherited? Are there other associated concerns that we should expect in the future? Is there any medical treatment that will help?

Beyond the process of identification and initial evaluation, the medical contribution to the ongoing care and management of an infant with disabilities may be substantial. For some children, persistent or intermittent health problems can influence the implementation and effectiveness of individualized educational plans. Seizure disorders, congenital heart disease, recurrent otitis media, and chronic respiratory infections are some of the many health impairments that can impede developmental progress and that require close pediatric and/or subspecialty supervision. Children whose very survival depends on sophisticated medical technology, such as those who require supplementary oxygen or ventilator assistance, represent an extreme yet increasingly prevalent example of youngsters whose individualized service plans demand the integration of sophisticated health, education, and social services.

Finally, as the professional who is likely to have the most enduring relationship with a child and his or her family from birth through adolescence (for those families who have access to pediatric care), the primary care pediatrician can play a consistent, stable role in helping to provide family support, coordinate resources and facilitate the multiple transitions from the newborn nursery through early intervention programming, school-based special education, and vocational services.

3. Inappropriate assessment and premature labeling of children must be avoided; such practices have done harm, particularly to minority children, in a number of state and community programs ostensibly designed to enhance their development.

While we welcome opportunities to serve new groups of infants, toddlers and their families, we must recognize that early intervention services as described in P.L. 99-457 cannot be all things to all vulnerable young children. Many infants, toddlers and families

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need other types of community-based support if they are to achieve their full potential, and many need a combination of early intervention and other health, education and social services. The population to be served through P.L. 99-457 must be defined with great care.

Much has been written about past abuses of psychological evaluation. We have ample evidence that the current state of the art in child and family assessment is sufficiently ambiguous to warrant extra concern about the potential risks of categorizing either the abilities of very young children or the functioning of their families. One of the minimum components of a statewide system for children birth through age two under P.L. 99-457 is "performance of a timely, comprehensive and multidisciplinary evaluation of the functioning of each handicapped infant and toddler, and the needs of the families to appropriately assist in the (child's) development." We must ensure that such assessments are as appropriate and sensitive to the very young children (and the families) involved as they are comprehensive and timely.

We need to be extremely cautious in any broad scale implementation of assessment and intervention strategies. When there are risks that certain groups may be stigmatized by evaluation procedures, we need to be doubly sure that assessments help children, families and communities view themselves positively. We must ensure that services proposed for a child and family grow logically out of their assessments, and that they make good conceptual sense. Services should also emphasize positive roles and outcomes as much as possible, for everyone involved.

Frequent parent and professional review of individualized family service plans and other procedural safeguards for parents under P.L. 99-457 will be important mechanisms for monitoring the benefits of assessment and early intervention programs. In addition, research efforts supported by P.L. 99-457 funds should be directed toward increasing our capacity to understand the complexities of child development in our multicultural society, to assess appropriately the functioning of individual children and families, and to offer relevant services of whose value we are confident.

4. Responsiveness to parents, by both service providers and state and local agency decisionmakers, is central to accomplishment of the goals of P.L. 99-457.

P.L. 99-457 recognizes families as central to the development of children and underscores the primacy of parents in the lives of their infants and toddlers. The section of the law on the individualized family service plan, for example, requires a statement of family strengths (as well as needs) related to enhancing the development of their infant or toddler with disabilities. Parents should whenever possible be asked to help write the family service plan, not just review it. Similarly, the child find system and public awareness programs that must be components of statewide systems will be enhanced if parents help to plan *and* to implement them.

In many other areas as well, P.L. 99-457 offers opportunities for families to use their strengths on behalf of their own and other young children with disabilities. Parents can be service providers and care managers as well as service recipients. They can be trainers as well as trainees. They can help to evaluate the functioning of service programs as well as be involved in the assessment of their own child and the functioning of their family. They can advise as well as "be informed."

The opportunities presented by the language of P.L. 99-457 must still be translated into regulations. Regulations, in turn, must be used to guide actual programs and practices so that these recognize, support and use family strengths, as well as respond to family needs. When parents and professionals work together in each step of this process, opportunities may have the best chance of becoming realities.

5. Preparation of qualified personnel for early intervention will be critical to the effectiveness of expanded early intervention efforts.

The House Committee on Education and Labor's report on P.L. 99-457 described concern that "shortages of qualified personnel in the provision of special education and related services to handicapped children are reaching crisis proportions." The committee report specified further that grants under the new legislation prepare people with the knowledge and skills needed to work effectively specifically on behalf of handicapped children from birth to age five.

Practitioners, parents, researchers, teachers and students concerned with infants and toddlers have long recognized the need for both preservice and inservice training directed toward specific competence in understanding and enhancing the development of children in the earliest years of life. We recognize as well the importance of preparing professionals to

The Education of the Handicapped Act Amendments of 1986

(P.L. 99-457) were signed into law on October 8, 1986. The Act creates a new discretionary program to assist states to plan, develop and implement a comprehensive, coordinated interdisciplinary program of early intervention services for handicapped infants and toddlers and their families.

Fourteen minimum components of a statewide system of services for handicapped children from birth through age two and their families are specified in the Act. These include:

1) A definition of "developmentally delayed" to be used by the state
2) A timetable for services to all in need in the state
3) Comprehensive multidisciplinary evaluations of needs of children and families
4) Individualized family service plan and case management services
5) A child find and referral system
6) A public awareness program
7) A central directory of services, resources, experts, research and demonstration projects
8) A comprehensive system of personnel development
9) A single line of authority in a lead agency designated or established by the Governor
10) A policy pertaining to contracting or making arrangements with local service providers
11) A procedure for timely reimbursement of funds
12) Procedural safeguards
13) Policies and procedures for personnel standards
14) A system for compiling data regarding the early intervention programs

Copies of P.L. 99-457 are available free of charge from the Senate Document Room, Hart Senate Office Building, Room B04, Washington, D.C. 20510-7106. Requests should be accompanied by self-addressed gummed labels.

It is anticipated that draft regulations concerning P.L. 99-457 will appear in the Federal Register early in the spring. The Federal Register is published by the Superintendent of Documents, U.S. Government Printing Office, Washington, D.C. To find out whether the draft regulations ("proposed rule") have been published, one may call the Federal Register's information office, tel: (202) 523-5227, and ask for information about the Department of Education's proposed rule concerning the Education of the Handicapped Act Amendments of 1986. The Federal Register Office will not, however, have advance notice of the date of publication of the proposed rule.

collaborate effectively with parents, to function as members of interdisciplinary teams and to work with a variety of human services agencies. Ongoing supervision and collegial support should also be considered as essential elements of staff development. The nurturance of experienced staff is at least as important as recruitment of qualified new personnel.

As regulations are proposed for state and regional training and technical assistance efforts under P.L. 99-457, professionals and parents should think about ways to shape and contribute to these undertakings. For example, parents who have formed non-profit organizations have distinctive and valuable contributions to make to the training both of other parents and of professionals. Professional organizations, as well, have a role to play in formulating the basic competencies needed by any individual who works with infants, toddlers and their families. State level consortia of early intervention practitioners have creatively stretched meager resources to help members update their knowledge, refine specific skills and learn from each other's experience; they should be able to expand training efforts that have proved helpful both within-state and on a regional level.

Commenting on P.L. 99-457

We believe that P.L. 99-457 offers important opportunities to respond to the needs of vulnerable infants and toddlers through services that may become increasingly well integrated and increasingly sensitive to families with young children. But legislative opportunities do not bring real benefit to children and families until they are translated into federal and state regulations and until these regulations are implemented effectively.

The practitioners, researchers, teachers, parents, planners and administrators who make up the readership of *Zero to Three* tend to have both a profound respect for the uniqueness of every infant and family and a lively sense of the benefits of collaboration among parents and professionals, among disciplines, and among institutions.

We hope that *Zero to Three* readers will comment on the proposed P.L. 99-457 regulations. We hope that you will also become involved in the planning process in your states, bringing to that process your varied perspectives on new and creative approaches to foster the healthy development of infants and toddlers.

Let us know what happens.

Infant Day Care Responses

The September, 1986 issue of Zero to Three, which focused on aspects of child care for infants and toddlers, occasioned a number of responses from our readers. We are pleased to publish these additional perspectives on this important area of concern, including further reflections by Jay Belsky.

Selective Review of Infant Day Care Research: *A Cause for Concern!*

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In the September, 1986 issue of *Zero to Three,* Jay Belsky states that "entry into care in the first year of life is a 'risk factor' for the development of insecure-avoidant attachments in infancy and heightened aggressiveness, noncompliance, and withdrawal in the preschool and early school years" (p. 7). This is a startling conclusion with far reaching implications for both political and personal decisions about reliance on infant day care. And despite the caveats and qualifiers sprinkled throughout the article, it is this grave pronouncement that will become the heritage and most quoted of Belsky's remarks.

This is unfortunate. Belsky's admonition that infant care—apparently *any* nonmaternal infant care—exposes infants to risk constitutes one individual's interpretation of research on infant care that is at best, selective, and at worst, misinterprets the available data. Under any condition, a selective review is cause for concern. But when the stakes are as high as they are in the area of infant day care—anxious parents and precariously funded programs—the review requires careful scrutiny, and, we believe, substantial revising.

With respect to the issue of insecure attachment, Belsky refers to, but does not report, the results of a meta-analysis of research examining the influence of child care on infant-mother attachment. This meta-analysis was conducted by two of the current authors (McCartney & Phillips, in press). The complete findings will soon appear in an edited volume of research on motherhood (Birns & Hay, in press).

Belsky implies that the meta-analysis was biased by the family status and ideology of the authors. A meta-analysis is a statistical method for analyzing the combined results of multiple studies that, by definition, holds less potential for bias than a personal literature review. Several precautions were also taken in this instance: a search of *Child Development Abstracts and Bibliography* was conducted, excluding only those studies that did not use the Strange Situation to assess attachment or that did not report data for proximity to mother and avoidance of mother. Fourteen studies were identified. A research assistant who was unaware of the purpose of the analysis coded each of the articles. Finally, given the frequent criticism of meta-analysis on the grounds that less valid studies are given equal weight with carefully controlled studies, the moderating influence of methodological strengths and weaknesses of each study was explicitly examined.

What did we discover? Two results are important. First, the effect-size estimates for the four measures of attachment (explore, cry, proximity, avoidance) showed negligible day care-home differences. This suggests that children attending day care are no different than children reared at home on mother attachment as assessed through the Strange Situation. Second, the examination of methodological moderators revealed that ratings of avoidance were affected by whether judges were "blind" to the children's substitute care experience. Judges who were *not* blind were more likely to find differences between day care and home-reared children, such that day care children were rated as more avoidant. This documents an unfortunate experimenter expectancy effect.

Belsky draws heavily upon one longitudinal study—the Minneapolis sample studied by Farber and Egeland (1982) and by Vaughn and his colleagues (Vaughn, Deane, & Waters, 1985; Vaughn, Gove, & Egeland, 1980)—in his analysis of this attachment literature. It is critical for your readership to know that this research was designed to study early *mal*adaptation in parent-infant interactions. As described by Farber and Egeland, "The sample was drawn from a local maternal and child care clinic which serves families of lower socioeconomic backgrounds. The majority of the mothers were single and receiving some form of public assistance at the time their babies were born. Most of the pregnancies were not planned" (pp. 107-8). Infant day care, in this study, was most frequently provided by an adult female, often a relative or friend of the infant's mother. At least 80% of the infants experienced a change in the substitute caregiver during the period they were receiving out-of-home care. The authors conclude, "In sum, out-of-home care arrangements were quite varied and changes in these arrangements were a routine" (Farber & Egeland, p. 111).

We do not have any quarrel with Belsky's reporting of these data. They have been reported in reputable journals and edited volumes. Given the meta-analyses results and other available evidence, we do, however, question his subsequent conclusion that "the very child development outcomes associated with early entry into supplementary child care are the same as or at least similar to, those that have been implicated in the attachment literature as the (undesirable) child development outcomes correlated with early insecure attachment to mother " (p. 5). Nowhere is it ascertained, for example, to what degree the results of the Minneapolis project are due to the multiple family stresses associated with poverty or the unstable care arrangements of the children in conjunction with, or instead of, the age at which the children entered child care. And regardless of causality, we question the validity of premising a generalized argument about infant care largely on a sample of very low-income, single mothers with unplanned pregnancies and inconsistent child care.

One of us (Howes & Stewart, 1986) has recently completed a study that compares directly the influence of age of entry into child care and the stability of child care in 55 toddler-age children who were enrolled in family day care when they were between 2 and 23 months old. Only 36% of this middle-class sample stayed in the same family day care home from the time they entered day care until they were observed in the study. Children who changed child care arrangements more often were less competent in their play with peers. Boys who entered child care as younger babies and had few child care changes were most likely to engage in high level play with objects. This suggests that the stability of the child care arrangement is more important than the age the child begins child care.

It should also be noted that the results of the Schwartz study (1983), as discussed by Belsky, are overgeneralized. Belsky states that this study shows that "babies who began day care in the first year of life displayed greater avoidance of their mothers..." (p. 4). In fact, only those babies who began *full-time* care as infants showed greater avoidance of their mothers. Those in part-time care were not different in attachment from infants not in child care.

The only other available review of the research on attachment and infant care (Gamble & Zigler, 1986) is more circumspect in its conclusions, and we believe far more in line with the evidence. Gamble and Zigler state as a "tentative" conclusion, "*In families facing significant life stresses,* substitute care during the first year increases the likelihood of insecure parent-child attachments" (p. 35, emphasis added). And in an accompanying article (Young & Zigler, 1986), policy recommendations that include efforts to improve the quality of infant care and make parental leaves more widely available are outlined.

The second argument put forth by Belsky concerns the effects of infant day care on children's social development, specifically maladjustment and aggression. Belsky concludes on the basis of the Bermuda child care study (McCartney, Scarr, Phillips, Grajek, & Schwarz, 1982), data from the Abecedarian Project (Haskins, 1985), and data reported by Rubenstein, Howes, and Boyle (1981) that early infant care, "may also be associated with diminished compliance and cooperation with adults, increased aggressiveness, and possibly even greater social maladjustment in the preschool and early school-age years" (p. 6). In our opinion, a far more cautious and restricted conclusion is, in fact, warranted.

Specifically, the Bermuda study (also reported in McCartney, 1984; McCartney, Scarr, Phillips, & Grajek, 1985; and Phillips, McCartney, & Scarr, in press) did not examine "poor quality" centers, as Belsky claims (p. 7), but centers that ranged widely in quality from excellent to poor. The central purpose of this research was to examine whether variation in the quality of center-based care affects children's cognitive, language, and social development. Family background and age of entry into child care were controlled statistically prior to examining the effects of day care quality.

The most significant finding of this research is that child outcomes are affected by the quality of their child care programs. Age of entry into care showed only one significant effect out of a total of 20 outcome measures, while quality showed consistent effects. Child care is not a uniform intervention and should not be discussed as such—a point that has been emphasized by many reviewers of child care research (Clarke-Stewart & Fein, 1983; Etaugh, 1980; Rutter, 1981; Scarr, 1984; Zigler & Gordon, 1982), including Belsky (Belsky, Steinberg, & Walker, 1982). Just as home environments are not all the same, day care environments are not all the same, and some are better for children than others.

Belsky sidesteps this major finding, and states, instead, that the Bermuda study demonstrates that maladjustment is a consequence of early entry into child care. The "maladjustment" measure used in this study actually consists of three scales, each of which was rated by a parent and a caregiver. Only *one* of the six ratings showed a significant effect for age of entry—caregiver ratings of children's anxiety. Moreover, quality of care was just as important a predictor of the caregiver anxiety ratings as age of entry. Perhaps most important, we must ask if any of the children in the study were, in fact, overly anxious. The answer is no. The actual range of caregiver anxiety ratings was 1.00 to 2.67 on a scale on which the highest possible score is 10.00. Thus, the highest score actually obtained for a child in this study was 2.67—a score of 6.73 is considered "anxious" by the authors of the scale (Behar & Stringfield, 1974). So to portray any of the children in this study as over-anxious, let alone maladjusted, is inappropriate.

Belsky also bases his conclusions about the social development of children who enter child care as infants on a study conducted by Haskins (1985). Belsky characterizes these data as showing greater aggressiveness for "children who received center-based care in the first year of life, in contrast to those receiving care at any time thereafter..." (p. 6). In fact, Haskins states that "my results will not support these conclusions" (personal communication, October 1986).

What Haskins' data *do* show is that "children with extensive experience in a cognitively-oriented day-care program were rated by their public school teachers as more aggressive" (p. 700). In direct comparisons with children who had extensive experience in licensed child care centers that did not place a great emphasis on a cognitive curriculum, significant differences emerged, such that only the children in the cognitively-oriented programs showed higher aggressiveness upon school entry. Thus, we must again circumscribe Belsky's conclusions—they apply only to children who attended a single intervention program with a particular type of curriculum. In fact, the children with extensive experience in licensed child care centers showed *lower* amounts of hitting, kicking, and pushing than did children with less day care experience.

The results of the Haskins study relate directly to questions about the type of day care curriculum to which young children are exposed. They have little to say about age of entry into child care and, to the extent that conclusions can be drawn about *amount* of day care experience, it appears that this factor alone does not predict aggressiveness in kindergarten and first grade. These are quite different—almost opposite—conclusions from those that Belsky draws from this research.

A third published study that Belsky cites to draw conclusions about the social development of children who enter child care as infants was conducted by Rubenstein, Howes, and Boyle (1981). In this study, preschool-age children who had been in child care as infants were found to be less compliant when asked by their mothers to complete a boring task than children who had been at home. Furthermore, mothers of child care children reported more temper tantrums than mothers of children reared exclusively at home.

Belsky does not, however, report a follow-up study of these children (Rubenstein & Howes, 1983) which revised several of the conclusions reached in the initial study. Thus, the authors later conclude that "For later emotional development, individual differences in the actual experiences and behaviors of the toddlers in day care are more important than is attendance in day care per se. We found that later behavior problems, test anxiety, and aspects of the mother-child affective relationship were predicted by individual differences in the toddlers' experiences and behaviors in day care and they were not predicted by whether the toddler had been in day care or at home" (pp. 41-42).

Similarly, Howes & Olenick (1986) report that toddlers in high quality child care centers demonstrated accelerated self-regulation while toddlers in low quality centers lagged behind both children who were in high quality centers and at home with their mothers. Therefore, when critical studies are not eliminated from the review, they converge to suggest that early entry into day care may be less important than the kind and quality of care children receive while in day care.

An additional problem must be noted with respect to Belsky's review of research on the social effects of infant day care. On page 5, he refers to the Farber and Egeland (1982) study and concludes, "Not only was it the case that toddlers whose mothers began working prior to their infant's first birthday displayed significantly less *enthusiasm* in confronting a challenging task than did children who had no day care experience, but it was also the case that these day-care-reared infants tended to be less *compliant* in following their mothers' instructions, less *persistent* in dealing with a difficult problem, and more negative in their *affect*."

In fact, only one of these results showed *significant* effects for the mother's work status—enthusiasm—and then *only for boys*. The other results failed to reach significance, e.g., $p = .09$ for compliance, $p = .13$ for persistence, $p = .10$ for negative affect. Nonsignificant group differences are also included among significant effects in Belsky's reporting of Schwarz, Strickland, & Krolick (1974) (Schwarz, personal communication, October, 1986). It is highly unconventional to report nonsignificant effects as reliable group differences.

Finally, it is instructive to examine other evidence which should also be weighed in a comprehensive review of the effects of infant day care. Benn (1985), in a study of 41 upper-class children from intact families using family day care homes with fewer than 3 children or a sitter for child care, found that male infants who started child care during the latter half of the first year of life were more likely to be insecurely attached to their mothers than were male infants who began child care earlier. Howes & Rubenstein (1985) report that children who entered center or family day care earlier (children entered between 2 and 15 months of age) had higher frequencies of touching and laughing with their caregiver than children who entered care later. Schwarz and his colleagues (Schwarz, Krolick, & Strickland, 1973) studied peer interactions among children who entered center-based care earlier (5-22 months, average = 9.5 months) versus later (24-47 months, average = 36 months). The results showed that the early entry group exhibited more positive affect upon entering the peer group, showed less tension upon entering the group and five weeks later, and also had higher (more positive) social interaction scores than the late group on day one and five weeks later.

Scientists who study controversial and emotion-laden issues sometimes find it difficult to suspend judgment in the face of complex and contradictory research evidence. Infant day care is among the most controversial and emotion-laden issues that developmentalists study. It is precisely under these circumstances, however, that it is incumbent on the scientific community to use the utmost caution. Sometimes "good science" means saying "I don't know—the evidence is inconclusive." At a minimum, when we venture to draw conclusions from a relatively small and contradictory collection of research evidence, we must qualify our conclusions to explain to whom they apply, under what circumstances, and with what remaining questions.

The evidence on infant day care is not all in. In fact, carefully controlled studies of infant day care are rare. Yet, we do know that quality makes a difference and that treating infant child care as a homogeneous environment fails to reflect the real diversity of infant care. We also know that the existing data confound family stress, the child's age of entry into care, the length of time in care, and the stability and quality of care, thus leading us to be very cautious about attributing the consequences of care to any single one of these variables. Many other equally important issues have received scant empirical attention, such as the role of child care as a support system for working families and the role of fathers in children's (and mothers') adjustment to child care.

Of course, any *consistent* findings of detrimental effects would be cause for concern, as noted by Belsky. And any clues in the research literature about how to define high quality infant care should be studied carefully. This latter issue is particularly compelling. Because, while we continue to debate the merits of infant care, the realities of economic and demographic life in America tell us that infant day care is here to stay.

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Risks Remain

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Several years ago I wrote a chapter entitled "Two Waves of Day Care Research: Developmental Effects and Conditions of Quality" (Belsky, 1984) in which I updated past reviews of research on day care and child development (Belsky & Steinberg, 1978; Belsky, Steinberg, & Walker, 1982). In it I concluded that under certain specifiable conditions (e.g., modest group size, well-trained staff, supervised family day care providers) children's day-to-day experiences in day care are developmentally facilitative (e.g., more positive interactions with caregivers and agemates, less aimless wandering) and, as a result, children's development is enhanced. Future investigations, I pointed out, needed to move beyond "between-group" analyses which compared children with and without day care experience and employ "within-group" designs that permitted analysis of the conditions under which day care experience enhanced or undermined children's development. I was so pleased with this paper and the way in which it sidestepped the entire day-care debate that I promised myself I would refrain from further reviews of studies comparing children with and without experience in child care programs. Since day care was here to stay, I reasoned, the most useful knowledge would come from research that examined variation in children's experience in day care and sought to identify the conditions of quality.

This point of view which I embraced but a few years ago and, on the basis of my initial *Zero to Three* article (Belsky, 1986) now *seem* to have abandoned, is a basic message of my critics' analysis of my essay on infant day care. It is not one with which I have any disagreement whatsoever. Why then have I broken a promise to myself and risked the wrath of colleagues and other child care professionals? The reason is simple. As I stated in my article entitled "Infant Day Care: A Cause for Concern?," evidence kept crossing my desk which was directly at odds with conclusions I had reached in my original analysis of day care research (Belsky & Steinberg, 1978), yet consistent with findings that first captured my attention while writing my second and third reviews (Belsky, 1984; Belsky, Steinberg, & Walker, 1982). As I focused more and more upon these studies my attention was drawn not only to a possible relation between insecurity of attachment and *care initiated in the first year*, but also to evidence on such infant care which I had read before but had never defined in terms of such a restricted developmental period. Children who initiated care in the first year, the evidence suggested to me, seemed at risk not only for insecurity but for heightened aggression, noncompliance, and possibly social withdrawal in the preschool and early school years.

My first response to discerning such trends in the literature was to search for possible moderators of these associations between care initiated in the first year and children's social and emotional fucntioning. Could it be that the risks mentioned in my original essay were evident principally when care was of low quality, when it was provided in one locale versus some others, or when children came from certain kinds of families, were males or females, or began care early or late in the first year? Try as I did to discern order in the studies which focused upon children whose child care experiences were initiated in their first year, I found that there was insufficient grounds for concluding that any parameter which I considered was principally responsible for the risks which I thought (and still think) I had found to be associated with day care initiated in the child's first year of life.

In fact, much as I would have welcomed the opportunity to conclude that it was the quality of care in the first year which distinguished studies finding and not finding problematic developmental "outcomes" to be associated with care initiated in the first year, I discovered there was just too much evidence, given the dearth of studies actually focusing upon quality of care in the first year, that was inconsistent with this conclusion. Consider first in this regard the fact that the soon-to-be-published study by Barglow et al. (in press) linking insecurity and day care initiated in the first year was of infants from economically well-off families using good quality care. Consider next the fact that in the Haskins' (1985) study of aggression in the early school years, it was only the children with 60 or more months of care experience when they entered kindergarten (i.e., had been in care since their first year) who displayed heightened levels of aggression and that all these children had experienced center-based care of the highest quality. Consider, too, the fact that the Howes and Olenick (1986) study which Phillips et al. cite as evidence that quality matters most (and it might) deals with children 18 months of age and older and says nothing about when these children started day care and what the quality of their care was in their first year. This latter point also pertains to my critics' citation (and quotation) of the Rubenstein and Howes (1983) report, since it was experiences measured in the *second year of life* which predicted three and a half year functioning; also noteworthy is the fact that this report presented the same evidence which I cited in my original essay indicating that behavioral differences existed in the functioning of preschoolers who had and had not experienced center care in their first year.

The point of this discussion is not to argue that quality of care does not matter. That it does is best demonstrated, I believe, in the Bermuda studies (McCartney, Scarr, Phillips, Grajek, & Schwarz, 1982), since it was infants in poor quality centers who seemed adversely "affected" by their care experience (and it was for this reason that I cited these studies as implicating poor quality centers). Rather my point is to argue, in direct response to the criticism that I have failed to consider variation in quality of day care, that when information pertaining to quality of care is considered across research reports that the data are by no means as consistent as one might like and certainly not consistent enough for me to feel confident in saying that if there are risks associated with care in the first year of life it is as a result of quality and not age of entry.

Phillips et al. are disturbed by my suggestion that they, like me, might be affected by ideological and personal biases when it comes to evaluating research on the developmental correlates of day care. But it is hard not to feel justified in noting this *possibility* when they contend that I have premised "a generalized argument largely on a sample of very low-income, single mothers, with unplanned pregnancies and inconsistent care." If the only data I had to go on were those from the Vaughn et al. (1980) study to which they refer, then it would have been totally irresponsible for me to make the arguments I did in my essay. But the fact of the matter is that it was evidence from supposedly nonrisk samples which convinced me that I had little choice but to write the essay. It is time that my critics opened their eyes to the fact that there *are* data in the literature that pertain not to just extremely high-risk samples and refrain from casting all opinion which dissents from their mainstream line of argument as being based upon a single and supposedly discredited study or upon the diatribes of extremist ideologues whose rhetoric far exceeds the evidence.

It will not do either to imply that I have misrepresented the evidence which I cite as my critics note that not all the group differences I mentioned in the Farber and Egeland (1982) study reached traditional levels of statistical significance. But I am bothered by the implication that I intended to mislead; in fact, I constructed my sentence in a most deliberate manner to *contrast* the significant difference on the enthusiasm variable with differences on other variables which were purposefully cast as trends not achieving conventional levels of significance. And while it is also true that I erred in citing four differences as significant in the Schwarz et al. (1974) study, Phillips et al. commit a comparable error by implying that more than one difference which I cited was nonsignificant (i.e., .05) when, in fact, *three of the four* group differences which I cited did meet the conventional .05 significance level. In all this discussion—by Phillips et al. and by myself—we should not lose sight of the fact that criteria of significance, statistical or otherwise, reflect social conventions and are not engraved in stone on some tablet handed down from some all-powerful force. Group differences that are marginal and qualify as trends in the common parlance of our science, I believe, should not be dismissed out of hand, particularly in the case of research on infant day care in which we *should* want to know if there might be evidence of disconcerting consequences.

In reading Phillips et al.'s critique of my essay, I am repeatedly struck by their unwillingness to restrict themselves to the focus of my paper—namely, care initiated in the first year of life. As noted above, I restricted my own analysis to this developmental epoch, *making no claims regarding care initiated at any other times* (despite implications to the contrary), precisely because it was here and only here that concerns had developed in my mind. My summary of the literature, then, which was never purported to be comprehensive (and could not have been given the space allocated), was not so much "selective," as my critics contend, as it was focused. As a result, I find little real inconsistency between the findings Phillips et al. summarize from McCartney and Phillips' (in press) meta-analysis which focused upon care through the preschool years and those emanating from my much more circumscribed inquiry. My general sense is that direct comparison of the two efforts to summarize research on day care is not truly possible given such striking difference in focus.

In view of the attention my critics draw to the contrasting conclusions which their review and mine generated, I must call attention not only to the empirical "noise" that may be introduced when research on care initiated in the first year and that focused on care begun thereafter are not distinguished, but also to the need for more sensitivity to the methodological requirements of research on attachment. In particular, special attention must be paid to the inclusion of subjects as young as five months of age in experiments with the Strange Situation in some day care studies (Doyle, 1975; Doyle & Somers, 1978) and to the employment of methods in other studies which required that important reunion behavior (avoidance, resistance) be noted during a single live viewing of the Strange Situation (Brookhart & Hock, 1976; Hock, 1980). The fact of the matter is that no investigator today would use any data collection method other than videotaping, which permits repeat viewing, nor endeavor to study the attachment behavior of infants under 10 months of age in the Strange Situation. Thus, by including studies with such problematic designs and methods in meta-analyses, the statistically oriented summarizer of research runs the risk of accepting the null hypothesis simply because of the potential insensitivity of the studies under consideration.

Whatever conclusions are reached, though, I think it is important to reconsider the total context in which information on infant day care is considered. All too often I sense that there are some who judge it irresponsible, if not dangerous, to raise concerns and draw attention to evidence that is disconcerting. Child care advocates like Phillips et al. assert that families and child care programs need to be protected and come close to implying that any break in the ranks regarding the consensus conclusion that day care is fine and dandy is a moral transgression. There are several problems with this line of reasoning in my opinion. The first is that it assumes that any presentation of evidence indicating that infant care *as currently experienced in the United States* is associated with problematical developmental outcomes provides fuel for critics of nonmaternal care and the employment of women with young children. In view of the fact that, in all likelihood, such employment of mothers is here to stay, I would contend that such evidence provides ammunition for those who want more support for child care programs or more choices for parents rearing young children. Indeed, the child care system in this country is sufficiently limited, particularly in comparison to virtually all other western nations, that it may only be by marshalling evidence regarding risk that a politically significant case can be made that action must be taken. So long as child care advocates focus upon the policy risks and personal guilt that might be associated with analyses such as mine, opportunities to argue for support of child care may well be missed rather than taken advantage of. Indeed, in light of the absence of progress which has been made in this country in the policy arena since the failed implementation of the Federal Interagency Day Care Requirements, child care advocates may well want to consider alternative political strategies. Rather than avoiding or explaining away disconcerting evidence (and there is now a good deal of it), it might be wiser to embrace it and argue that current policies and the practices they introduce threaten the well-being of children and families in the United States.

Regardless of whether my critics accept this line of reasoning, I must alert them to the fact that many parents of young babies are trying to decide whether two incomes are absolutely necessary and whether it might be wiser to defer the return of the second parent (typically the mother) to the labor force until after the infant's first year of life (particularly given the options currently available). In reading my critics' response to my essay I am forced to wonder why it is that discussion of research by child care professionals is almost always cast in terms of families in which parents have no choice but to work. Although these may be the kinds of families with which they deal most often, as well as the ones with whom policy makers should be most concerned, it needs to be recognized that there exist a good number of families that could manage to forego two incomes, particularly if it turned out that a developmental period as narrow as the first year were identified as one associated with whatever risks might be associated with day care. I suspect, moreover, that such families would very much like to have such information were it to become available. Consideration of such families reminds us that no policy position has a monopoly on the risk or utility associated with scientific evidence. Due consideration must be given, in terms of analyses of the developmental correlates of infant day care, to those families in which mothers choose to stay home (or are still deciding), not just to those in which mothers must work.

The essay I wrote reflected my desire to bring to the attention of child care professionals the fact that, in contrast to just five or ten years ago, there exists now a sizeable body of evidence linking care initiated in the first year of life with patterns of child functioning that ought to be a cause for concern. This is not to say that benefits do not arise from nonmaternal care or that such disconcerting correlates of early care are found in every study, characterize every child, are inevitable or even are caused by experience in infant day care arrangements as routinely experienced in the United States today. In view of the fact that it remains unclear, given the current state of the evidence, under which conditions these correlates of care are most likely and most unlikely, it seems appropriate to characterize infant day care as a risk factor. This phrase does not imply that risk is inevitable, only heightened. Future research, we must hope, will illuminate these very conditions. Future policy, we must further hope, will enable families to maximize their choices, with affordable and quality infant care being one of them.

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Comments: "Infant Day Care: A Cause for Concern"

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I wish to express my reaction to Dr. Jay Belsky's article, "Infant Day Care: A Cause for Concern." It is a curious article, in that it disclaims personal bias as a scientist, views with alarm those scientists who have personal bias that day care is not detrimental to child development, explains the great variability in quality and type of day care utilized by working parents, gives a nod to the hetereogeneity of family environments of children in day care, yet concludes that entry into day care in the first year of life is a risk factor for undesirable developmental outcomes.

I also wonder why Belsky places so much emphasis on the personal bias among the proponents of day care, and fails to give equal weight to the biases of opponents of day care.

I have read the excellent paper by Phillips, McCartney, Scarr & Howes taking issue with Belsky's article in terms of the selectivity of the day care research findings that he reports. I am grateful for their scholarship and careful statistical critique. My remarks will be clinical in nature.

Dr. Belsky's paper brings echoes of an earlier judgment spearheaded by the reports of Bowlby and Goldfarb that institutional rearing of children was always to be condemned. However, later careful studies by B. Tizard and Rees and J. Tizard and colleagues in the 1970's provided evidence that the issue was really a good versus a bad institution rather than a blanket attack on all institutions for children. We could now identify the factors that would make institutional care a positive experience. And we are finally brought up to date in the 1980's by the long term studies by Quinten, Rutter & Liddle showing that "Institution reared women showed a worse psychosocial outcome in adult life compared with controls, but there was great hetereogeneity, with some women functioning very well." Surely this outcome cries for an examination of the factors involved in the positive outcomes so that, when institutional upbringing is needed, it can strive toward increasing the proportion of those who have good outcomes. A cry of alarm over the poor outcomes ending in elimination of all institutional care is of no help unless it were true that all institutional care is in fact disastrous.

Surely we should not duplicate, with day care, this first overall condemnation, based primarily on the results of poorly functioning units.

A second point that strikes one in reading Belsky's article is his statement, highlighted on page 5 by repetition in large type, that "the child development outcomes associated with early entry into supplementary child care are similar to those undesirable developmental outcomes correlated with early insecure attachments to mother." As a clinician I am made quite uneasy by oversimplified one-to-one judgments. Throughout the article, the Ainsworth Strange Situation is assumed to be the valid mode of determining the child's actual attachment to the mother. Substantial clinical doubts have been voiced about the ability of a short, simple laboratory procedure to judge a complicated child-mother relationship. To quote Rutter (1981), who cautioned about drawing conclusions from "... curious procedures involving mother, caretakers and strangers not only going in and out of rooms every minute for reasons quite obscure to the child but also not initiating interactions in the way they might usually do." (p. 160). Also in the Strange Situation rating, the infants who ignore the mother when she returns are called "avoidant," indeed a pejorative term, and classified as insecure. But is it not possible that in a child who is confident that his or her mother will return after a brief absence, the mother's return does not call for any special recognition of this event?

Surely, in view of the fact that one of every two women with a child under one year of age is employed and hence needs child care arrangements, our aim should be to supply good substitute care to all these working women of all economic levels. An unsupported dictum that such day care is a "risk factor" can only cause unnecessary guilt among working mothers and provide ammunition for the many elements in our society who are hostile to the idea of spending public funds sufficient to provide good day care facilities for all young children.

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A Good Reference for Parents

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I want to speak to the article *Infant Day Care: A Cause for Concern?* You were brave to print the lead article. Questioning day care is not a popular position to take, as I am sure you are well aware as was the author.

The article is most useful. Parents, with whom I work, tend to see only articles which either outrightly advocate non-parental early infant care or deny any possible negative outcome. The author's judicious approach makes the research summary a good reference to give parents another body of information to use when making decisions about their children.

Unfortunately, as the author recognizes, his sex makes the article even more political. It is too bad he had to focus for comparison on the maternal/infant relationship. He had no alternative, of course, as that relationship is the traditional one and the one that has been studied.

I look forward to seeing how your organization with its focus on infant health will translate the implications of the article into action. Society has tended to give economic reasons for the mass movement of women into the labor force. For the majority of women this appears to be true. But as writers and polls have been reporting for several years as high as 80% ofthe women in paid employment would work outside the home, even if they did not have to for financial reasons. I analysed this phenomenon in a paper for the Parenting Symposium, *Parenting: the Road to Being a Nobody.* Women, as men did before them, have moved into the paid labor force for many reasons; economic need is only one. If nonmaternal care puts infants at risk, what options should/can be offered?

A Timely and Controversial Article

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As a social work practitioner and a director of a center-based early intervention program for children with handicapping conditions, I found Jay Belsky's article to contain the stuff upon which much debate and conflict has centered in our program. We have been very concerned that we may be neglecting the emotional growth and psychological well-being of some of our infants while we focus on or emphasize their physical, medical, and educational needs. On the other hand, we have also been concerned about providing appropriate and vital services to parents and families.

I would like to share several concerns which the article has generated:

1 I think it is important to separate out *early intervention* for developmentally disabled children or children at risk for developmental delay from the non-handicapped infant and preschool population in this particular debate. The article did not address the needs of this population—needs that are *great* for: prevention, early identification and detection, diagnosis, early treatment and rehabilitation, parent support, parent training, family assistance, etc.

In this particular area of early intervention, I have found that the question of whether or not we should be intervening in the first year of life is being pondered *mainly* by professionals and *not* by parents of children with handicapping conditions. I see this as an important point worthy of our consideration as professionals. There is no "too early" situation for any of the parents we have serviced regardless of socioeconomic status, level of education, income, etc.

If human service provision is supposed to match human need, then there is a high correlation between what we propose to do and what consumers are expressing as felt need.

2 It is important to provide various alternatives of high quality for all families in our society. Families with disabled or at-risk children are especially vulnerable and in need of multiple options and strategies for child care arrangements, respite, education, prevention, and treatment. For these families, the sooner, the better. Parents have told me this consistently. Of course, the quality of the care and the philosophy of the care provider with regard to the issues of separation, individuation, and emotional bonding with the parent are critical components of early intervention for these families, as well as others. However, it is possible to incorporate varying levels of parental or maternal involvement to *counteract* the threat or risk of insecure-avoidant attachments in infancy with the subsequent negative behavioral manifestations in later years. How to do this is where, I believe, professional energies should be mobilized.

3 The article suggests that either the danger exists or it doesn't exist—an "all or none" conclusion. I disagree. You can have a center-based or "non-maternal child care arrangement" which builds in a home component or outreach piece.

There are other ways of modifying the possible negative consequences of early intervention that lacks on-going *maternal* involvement. What about working with siblings? What about grandparents? What about fathers? I believe that the definition of "maternal" in the article is quite restrictive and traditional when we look at actual child-rearing practices and the constellation of the family unit today.

4 If, as practitioners, we can begin to look for noncompliant behaviors or affective disorders early in infants who are enrolled in our programs, we can work with this insight and be on guard to make necessary changes. Our programs need to be flexible enough to adapt treatment plans and approaches to the changing demands and needs of each individual child and his/her family. Our interventions cannot be immutable so that we become counter-therapeutic.

Since we do not know how permanent these negative effects are in children, I agree that we need to monitor ourselves for these potential impacts and change *our* behaviors as staff and providers accordingly.

The issue for us is how to measure our effectiveness or lack of same rather than how early we should be providing child care outside of the home for handicapped children.

5 Finally, if we are seeing a possible detrimental impact of our current models on children and their families, then it is our responsibility collectively to advocate for changes in funding mechanisms and for changes in legislation for preschool. I say this because the center-based alternative happens to be the design that fits our funding package. If we need to re-design our intervention modalities, then we need to change the funding structures so that programs are not dictated to by funding requirements and directives.

While I respect the analysis and thoughtfulness demonstrated by the author in this article, my own moral bias cautions me against looking to substantiate a thesis which might lead policymakers to opt for *less* or *later* involvement with families at a time when programs, like ours, are in jeopardy of having funding reduced or, at best, closely scrutinized with the goal of reduction.

I believe that we need to mobilize our resources to enhance the out-of-home and in-home child care arrangements that already exist for families, especially those for families with handicapped children.

Model Versus Modal Child Care

ALICE FITZCHARLES, MEd, LMSW,
Media, Pennsylvania

I was deeply moved by the issue on day care, September, 1986. Having worked as interim director for just a few months in a "modal" child care center, I recall the mental anguish and indignation over the treatment of the children, the lack of training and sensitivity of the caregivers. The "high risk" children are those *most* in need of the *highest quality* care, not the poorest. In good moral conscience, I could not accept the job of permanent director offered to me, because I knew the financial resources to improve the situation were unavailable. Since then, there have been a *few* improvements, but far from enough. And we all know, these children can't wait for better care; their development is being hindered as I write this letter.

I *do* write my senators and representatives. What else can I do? There should be a national campaign to educate the public about the needs of infants, how their needs must be met, and what situations will come upon them, and *us*, if they don't receive quality care. Perhaps future issues of *Zero to Three* will give me some reason for hope for improvement of day care for low-income children, and suggestions of what I can *do*.

National Center Notes

by Eleanor S. Szanton

As a bemused friend of NCCIP once told us, "Sometimes I think you believe life begins at zero and ends at three!" Not so. Many National Center Board members and staff, as well as other infancy professionals, entered this field after our work with pre-school or school-age children had given us a sense that opportunities to help these children at an earlier age had been missed. We continue to recognize the importance of an appropriate, integrated and adequately funded continuum of developmental services for infants, toddlers, pre-school and school-age children and their families.

Why then, do we maintain a focus, particularly in public policy and public education activities, on the first three years of life?

First of all, as advocates for children have long recognized, pointing out the needs of an age group can be a way of directing attention to more general human needs. Yet to think too broadly about "children" in a public policy context may be a disservice to all age groups — children who are seven or seventeen years old have distinct needs that are as different from each other as they are from those of an infant of seven months. Lumping "children" in a common statistical slot — whether for purposes of data collection or funding of services — does not reflect the complex realities of development. The National Center exists, in part, to remind the public, human services advocates, and policymakers of the special situation and unique human needs of children and families in the first three years of life.

There is another reason why we speak out specifically for "infants and toddlers:" it stems from our research and clinical experience of the interrelatedness of multiple lines of development, especially in the early years. Physical, cognitive, emotional and social growth affect each other in powerful ways. We know, too, that even the youngest infant affects his or her parents and caregivers, as well as being shaped by experiences in the environment. We therefore want to know — "What are these children and families experiencing in all areas of their lives?" "What *else* is going on with this baby?"

As their names suggest, many services available to infants, toddlers and their families had their origins in concern over a specific problem, population or need — consequently we have "education for the handicapped," "supplemental food programs for women, infants and children" and "child abuse hotlines." It has often been lonely work for practitioners, planners, and, especially, parents to find and coordinate the services appropriate for the *whole* infant or toddler, and for his or her family. In local human services organizations, in federal and state agencies and in committees on Capitol Hill, we seek to "slice the pie the other way," to expand awareness of the interaction and intersection of multiple lines of development in the early years. We work, too, for approaches that are likely to strengthen, not fragment, families with young children.

Many years ago, the Children's Bureau was established to provide a focus for governmental attention to the broad needs of children. The House Select Committee on Children, Youth and Families and the Senate Children's Caucus represent recent Congressional efforts to investigate the general circumstances of children and families as well as specific problems. State prevention initiatives are beginning to take this broader perspective as well. The National Center, drawing on the experience and wisdom of those who work with infants, toddlers and families will continue to remind policymakers of the special capacities and needs of the whole child in the crucial years at the beginning of life.

Call for Papers:

Proposals for presentations are invited for a national conference to be sponsored by the *Division for Early Childhood (DEC)* November 1-3 , 1987 in Denver, Colorado. Proposals must be postmarked by **March 15, 1987.**

A broad range of topics and presentation formats is sought. Topics may address state of the art in assessment, diagnosis, treatment, service delivery, family involvement and evaluation concerning infants and young children with special needs. Other topics include policy development and advocacy issues; interdisciplinary or interagency collaboration; personnel preparation; administration; and low—incidence populations.

For information on selection criteria and proposed format contact Barbara J. Smith, c/o The Early Childhood Research Institute, Western Psychiatric Institute and Clinic, 3811 O'Hara Street, Pittsburgh, PA 15213, tel: (412) 431-3371.

The ERIC Clearinghouse on Elementary and Early Childhood Education is part of a nationwide information system designed to select significant material, enter items into a data base, and provide information analysis, products and other user services. The Clearinghouse of Elementary and Early Childhood Education encourages submission of research reports, conference papers, instructional materials, program descriptions and evaluations, curriculum guides and position papers having to do with the education or development of children from birth through early adolescence. Papers accepted as ERIC documents will be available at ERIC microfiche collections or through the system's Document Reproduction Service.

Individuals interested in having their papers considered for inclusion in ERIC should send two copies to : Acquisitions Coordinator, ERIC/EECE, University of Illinois, 805 W. Pennsylvania Avenue, Urbana, IL 61801 or call Sylvia O'Connor at (217) 333-1386 for further information.

Publications:

The Nurturing Father—Kyle Pruett (New York: Warner Books, Inc., 1987) $18.95.

This volume grow out of a five-year study of families in which fathers were the primary nurturers of their infants. Kyle Pruett studied the babies (using observation, the Yale Developmental Schedule, and, as the children grew, play interviews), the fathers themselves, and their spouses, with special emphasis on the singular impact of the baby/father connection.

The babies thrived, and in their earliest years seemed to develop precociously in many areas. Pruett resists a "father versus mother" approach of these findings, however; he suggests that babies whose fathers are primary nurturers may do exceptionally well because of the abiding commitment by *two* parents (instead of the traditional mother-plus-halfhearted-father) to the infant's well being and growth.

The volume contains detailed narratives and analyses of the experience over five years of three representative families in which fathers were primary nurturers of their infants. In addition, Pruett explores issues of gender identity and role over the course of the life cycle; women's responses to paternal competence in the nurturing domain; the impact of support, or antipathy, in the social environment for nurturing fathers; and the crisis of divorce for fathers and children. He suggests "not that all men need to rear their children full time in order to become truly nurturing human beings, but that men must shape, and be allowed to shape, their lives so that they may discover and develop their own full creative talents as nurturing men."

Placing Infants at Risk: Parental Addiction and Disease-Hearing Before the Select Committee on Children, Youth and Families, House of Representatives, Washington, D.C., May 21, 1986 (available from the Select Committee, 385 House Office Building, Annex 2, Washington, D.C. 20515).

This document includes statements and supplementary materials presented at a hearing designed to explore the linkage between parental addiction and abuse and increased infant mortality and morbidity. Committee Chairman George Miller notes the substantial increase in the number of women using heroin, cocaine and stimulants; the use of alcohol by 61% of women 20-34; and the increase in smoking among teenage girls. The increasing numbers of pediatric AIDS cases are also noted.

Statement and fact sheets included in the document describe low birthweight and other infant risks linked to parental addiction and disease. A statement by Ann Wilson of the School of Medicine, University of South Dakota, emphasizes the severe damage to personality development of infants of heroin addicts occasioned by abuse, neglect, and unstable foster care.

Evaluating Early Intervention Programs for Severely Handicapped Children and Their Families—Leonard Bickman and David L. Weatherford, editors (Pro-Ed, Inc., 5341 Industrial Oaks Boulevard, Austin, Texas 78735, 1986) $19.00.

This book presents ideas generated at a conference on issues involved in evaluating the effectiveness of early intervention programs for severely handicapped children, especially in terms of impact on family functioning. Conference participants came from a variety of disciplines and were experts in one of three general categories: mental retardation, policymaking and evaluation.

The unique challenges to evaluating early intervention programs specifically for severely handicapped children and their families are discussed. The range of existing program and characteristics of the population are reviewed; evaluation design and measurement issues are explored. A section on policy and utilization discusses the production of knowledge useful to policymakers and program planners. Contributors include Donald Bailey, Leonard Bickman, Diane Bricker, Paul Doecki, Carl Dunst, Rebecca Fewell, Rune Simeonsson and David Weatherford.

Healthy Mothers, Healthy Babies: A Compendium of Program Ideas for Serving Low-Income Women (Washington, D.C: Department of Health and Human Services, DHHS Publication No. (PHS) 86-50209, 1986) Single copies are available free of charge from the National Maternal and Child Clearinghouse, 38th & R Streets, N.W., Washington, D.C. 20057. Requests for multiple copies may be made to Lori Cooper, Executive Director, Healthy Mothers, Healthy Babies, 600 Maryland Avenue, S.W., Washington, D.C. 20024, tel: (202) 638-5577.

In the spring of 1985, a committee of the 80-organization Healthy Mothers, Healthy Babies Coalition conducted a nationwide survey of programs providing prepregnancy and postnatal services to low-income women. This report contains descriptions of programs selected from the more than 1500 responses to the survey; a summary of other responses; a directory of all survey respondents; and a review of the literature and market research concerning health information education among low income populations.

In addition to strategies used by prepregnancy, prenatal and postnatal programs, individual chapters discuss breastfeeding, nutrition, substance use during pregnancy, rural populations, Native Americans, and adolescent pregnancy. A chapter on comprehensive programs notes that these programs, often located within established health, or social service agencies, were more likely than respondents in other categories to have statistical evidence of success. A Health Department program in Hobbs, New Mexico, for example, reduced the rate of pregnant women who did not seek health care until delivery from 28 to 5 percent, while the neonatal mortality rate declined from 25 percent to below 5 percent.

Temperament and Social Interaction in Infants and Children—Jacqueline V. Lerner and Richard M. Lerner, editors (San Francicso: Jossey-Bass, 1986) New Directions for Child Development, No. 31, available from Jossey-Bass, Inc., 433 California Street, San Francisco, CA 94104, $9.95.

The six chapters in this volume are designed to address a number of the empirical and conceptual issues involved in understanding temperament and social interaction in infancy and childhood. One direction of current research involves viewing temperament as interacting with, or as a moderator of, other variables, such as emotion, *within* the infant. Another focus sees temperament in relation to variables *between* individuals, such as the social relationships manifested in infant attachment relations or mother-child interaction.

The editors note that a division of theoretical opinion exists about the explanation for the process by which temperament is linked to other inter-individual and intra-individual variables. Chapters in the book reflect a number of different theories. Contributors include H. Hill Goldsmith and colleagues, Ross Thompson, Susan Crockenberg, Jacqueline Lerner, Nancy Galambos, Barbara Keogh, Michael Windle and Richard Lerner.

Working Papers on Process in Infant Mental Health Assessment and Intervention—Michael Trout (The Infant-Parent Institute, 501 South Sixth Street, Champaign, Illinois 61820, 1986) $24 postpaid.

The eleven papers in this 90-page volume are designed for the clinician beginning specialized work in infant mental health. They address core procedural issues in the field, including the rationale for home visits; cancellations, missed appointments, lateness and distractions; and building a service and referral network. They also examine psychotherapeutic concepts such as transference, countertransference and ambivalence as they occur in interactions among parents, infants and therapists. Case examples are used frequently. Papers attend to the specifics—describing, for example, areas of information that the therapist will want to cover in assessing an infant and family—but also offer a broader framework, suggesting that "the process of infant mental health treatment *is* the process of developing information. The history-taking does not end until treatment does."

The longest paper is entitled "On Countertransference and Its Threat to Research, Casework, Training and Clinical Practice." Trout suggests that "it is a real and present danger in infant mental health that we may design interventions that are principally responsive to our own need to not know too much, to not be overwhelmed, and to not be reminded of our own early experiences." He calls for training programs, collegial support and supervision that will assure every infant mental professional of a "therapeutic experience that assures his work will be free from influence from his own unresolved past" and that will enable clinicians, researchers and educators "to know how to learn from the parents who entrust themselves to us ... and to listen to the babies we claim to represent."

Investing in Quality Child Care: A Report for AT&T—prepared by Ellen Galinsky with contributions from Dana E. Friedman (November, 1986). Available free of charge from Mary Callery, Room 6117F3, AT&T, 295 North Maple Avenue, Basking Ridge, NJ 07920, tel: (201) 221-8324.

With funding from AT&T Personnel, corporate child care experts at Bank Street College of Education and The Conference Board interviewed more than 50 child care experts across the country, asking them: 1) What aspects of child care are most likely to ensure high quality? 2) What are the current barriers to achieving quality in child care? and 3) What corporate or labor initiative would make the greatest difference in improving the quality of child care services?

Recommendations from this inquiry form the basis of this 45-page report. Companies are urged to take specific steps, for example, to support and subsidize high-quality child care in the community and to serve as a model employer. The business community as a whole is encouraged to publicize the unmet need for child care in this country and its implications.

Authors of the report discovered that many misperceptions about the need for quality child care persist among decision-makers. They counter assumptions such as "Children do not learn much when they are young, so the training of caregivers is unnecessary" with information from current research and practice.

The Prevention of Mental-Emotional Disabilities-Report of the National Mental Health Association Commission on the Prevention of Mental-Emotional Disabilities (National Mental Health Association, 1986)-Commission Report (42 pages) available for $6.95 and Resource Papers (249 pages) for $15.95 from the National Mental Health Association, 1021 Prince Street, Alexandria, VA 22314-2971, tel: (703) 684-7722.

This report is an outgrowth of the work of the commission on the Prevention of Mental-Emotional Disabilities established in 1984 by the National Mental Health Association. It is based on the expertise of Commission members, the testimony of invited experts and contributions of special consultants.

The report covers the lifespan, including discussion of prevention opportunities before birth and during infancy. Services involving home visits by trained workers to infants and parents are deemed "a high priority for the prevention of mental-emotional disabilities." The problematic availability of quality day care services with stable staff and a low ratio of infants to caregiver is noted as a matter of social concern. Family support programs are seen as central in addressing the need of all families for services, information and emotional reassurance.

Recommendations are made for action concerning the prevention of mental-emotional disorders by the Federal government, states and community programs in areas of services, research, training, the workplace and funding.

Conference Call:

February, 1987

February 26-27: *Educational Programs for Pediatric Therapists, Georgetown University Medical School* and *Infantest Corporation* will sponsor an East Coast Symposium on Infant Assessment in Bethesda, Maryland. Instructors will be Georgia DeGangi and Joseph Fagan. For information, contact Georgia DeGangi, 3419 Oberson Street, Kensington, MD 20895, tel: (301) 949-1648

March, 1987

March 6-7: *The Blind Children's Center* and the *Children's Hospital of Los Angeles* will present a symposium on "The Visually Impaired Child: Medical, Development and Ethical Issues" in Los Angeles. T. Berry Brazelton will be the keynote speaker. General sessions will address physicians' and parents' perspectives on diagnosis of visual loss in infancy; medical and functional assessment of visual acuity in infancy; ethical issues regarding the imperiled newborn; and other topics. Contact Patsy Rahn, The Blind Children's Center, 4120 Marathon Street, P.O. Box 2159, Los Angeles, CA 90029-0159, tel: (213) 664-2153.

March 7: *Boston University School of Medicine, Wheelock College* and the *Federation for Children with Special Needs* will present a course on "Young Children with Special Needs: New Challenges for Parents and Professionals" in Needham, Massachusetts. Betsy Anderson, Margot Kaplan-Sanoff and Barry Zuckerman will direct the course. Contact the Department of Continuing Medical Education, Boston University School of Medicine, 80 E. Concord Street, Boston , MA 02118, tel: (617) 638-4605.

March 13-14: "People , Skills and Money: Building Comprehensive Community Services for Infants, Toddlers and Their Families" will be a two-day regional conference sponsored by the *National Center for Clinical Infant Programs and Schneider Children's Hospital of the Long Island Jewish Medical Center.* Plenary addresses, case presentations, panels and special interest sessions will examine ways to mobilize the resources essential to creating and maintaining high quality services for normal,disabled and at-risk infants, toddlers and their families. Faculty members include Edward Zigler, Michael Lewis, G. Gordon Williamson, Sally Provence, Vince Hutchins, Catherine Rowan, Jane Dustan, Mareassa Isaacs, Stephen Herman, Nancy Balaban, Patricia Nachman, Irene Hassett, Annette Axtmann, and Rebecca Shahmoon Shanok. For information contact Ann Boehme, Continuing Education Coordinator, Schneider Children's Hospital of Long Island Jewish Medical Center, New Hyde Park, New York 11042, tel: (718) 470-8650.

SAVE THE DATES!
NCCIP'S Fifth Biennial National Training Institute will be held in Washington, D.C. December 4-6, 1987. Watch Zero to Three for details.

March 13-16, April 4-7, June 13-16: *Symposia Medicus,* in association with the *Infant Stimulation Education Association,* will sponsor "Infant Stimulation: 1987," a course developed by Susan M. Ludington, in Las Vegas, Baltimore, and Detroit. For information about all three sites, contact Symposia Medicus, 2815 Mitchell Drive, Suite 108, Walnut Creek, CA 94598, tel: (415) 935-7889.

March 15-19: *The XIX Banff International Conference on Behavioral Science* will sponsor a conference on "Early Intervention in the Coming Decade: Identifying Robust Variables to Improve Clinical and Educational Practices" in Banff, Alberta, Canada. Faculty will include Frances Degen Horowitz, Craig Ramey, Glendon Casto, Steve Barnett, Rune Simeonsson, Phil Strain, Don Bailey, Patti Hutinger and Don Baer. For information contact Catherine Hardre, The Banff Center, P.O. Box 1020, Banff, Alberta, Canada TOL OCO, tel: (403) 762-6205.

March 25-28: *The Southern Association on Children Under Six (SACUS)* will hold its 38th annual conference in Memphis, Tennessee. General session speakers will be Bettye Caldwell, James Garbarino and Thomas Moore. Three conference strands will address the child in the family, the child in the group and the child in society. Contact SACUS, Box 5403, Little Rock, AR 72215, tel: (501) 227-6404.

March 25-29: The *American Orthopsychiatric Association* will hold its 64th Annual Meeting in Washington, DC with the theme "Toward Empowerment of Families: Strategies for Change." A one-day institute on infant and early childhood prevention will be given by Robert Nover. Other meeting sessions will address child development and child care; the family resource movement; chronically ill infants and children; and mother-infant rooming in on a psychiatric unit. For further information write or call ORTHO, 19 W. 44th Street, Suite 1616, New York, NY 10036, tel: (212) 354-5770.

March 27: *The Division of Pediatrics of Lutheran General Hospital,* Park Ridge, Illinois will present a symposium on "Continuing Care of the High-Risk Infant" at the hospital's auditorium. Faculty include T. Berry Brazelton, Jonah Deppe, Maureen Connors, Pati Matras, Reta Kinster, Beverly Sills, David Yoder and Luciano Dias. Contact Kim Walkup, Newborn Intensive Care Unit, Lutheran General Hospital, 1775 Dempster Street, Park Ridge, IL 60068.

March 30-31: The *U.S. Department of Labor,* in cooperation with the *AFL-CIO* and the *National Association of Manufacturers,* will sponsor a conference on "Work and Family: Seeking a New Balance." Alternative work patterns, parental leave, child and elder care and flexible benefits will be among the topics discussed. Speakers will include William Brock, Thomas Donahue, Stanley Gault and Colleen Dewhurst. Contact Patricia Presley, Cumberland Conference Coordinators, P.O. Box 398, Cumberland, MD 21502, tel: (310) 777-8701.

April, 1987

April 2-3: *The E. John Gavras Center* will sponsor its seventh Focus on Infants conference in Auburn, NY, featuring presentations on the assessment of sensory processing in infants and toddlers, a premature infant development scale, and fathers' interactions with babies. Michael Yogman, Georgia De Gangi and Judi Bierman will be among the faculty. Contact Focus on Infants, E. John Gavras Center, 182 North Street, Auburn, NY 13201, tel: (315) 255-2746.

April 3-4: *The Division of Developmental and Behavioral Pediatrics of the Boston University School of Medicine* will sponsor a course on "Behavioral Pediatrics: Clinical Problems in Primary Care" in Boston, Massachusetts under the direction of Barry Zuckerman. Topics to be discussed include malnutrition in early life; feeding and eating problems; the impact of maternal depression on children; child care practices in other cultures; and otitis media and development. Contact Continuing Medical Education, Boston University School of Medicine, 80 East Concord Street, Boston, MA 02118, tel: (617) 638-4605.

April 10: *Kennedy Memorial Hospital for Children* and *Boston University School of Medicine* will present a conference on "Coping with Transitions: Helping Disabled Children and Their Families," in Framingham, MA. James Perrin will be the keynote speaker. Write or call Mary Lou Fries, Director of Inservice Education, Kennedy Memorial Hospital for Children, 30 Warren Street, Brighton, MA 02135, tel: (617) 254-3800, x118.

April 21-22: *The American Medical Association* will hold a meeting on "AIDS and Public Policy: A Community Response" in Chicago, Illinois. Contact Robert C. Rinaldi, American Medical Association, 535 N. Dearborn Street, Chicago, IL 60601, tel: 645-5076.

April 22-25: *The Save the Children Foundation* will sponsor its tenth Family Day Care Technical Assistance Conference in Atlanta, Georgia. For information, call or write Joe Perrault, Save the Children, 1340 Spring Street, N.W., Suite 200, Atlanta, GA 30309, tel: (404) 885-1578.

April 23-24: *The Family Health Research, Education and Service Institute* will sponsor a conference on "Reproductive Casualties" in Alma, Michigan. The conference will focus on caring for families experiencing miscarriage, stillbirth or the birth of a sick or handicapped child. Effects of these losses on professional caregivers will also be addressed. A four-day seminar on infant mental health led by Michael Trout will be held in conjunction with the conference. For information, contact Kim Barnas, Family Health Institute, 503 N. State Street, Alma, Michigan 48801.

May, 1987

May 4-5: *The Michigan Association for Infant Mental Health* will hold its 11th annual conference on the theme "Infants and Families in Poverty" at the University of Michigan in Ann Arbor. Speakers will include Alvin Poussaint, Mary Lee Alan, Ron Haskins, Harriet McAdoo, Nancy Amidei and Michael B. Katz. Contact U-M Extension Service, Conferences and Institutes, 200 Hill Street, Ann Arbor, MI 48104, tel: (313) 764-5304.

May 30: The 18th Annual *Margaret S. Mahler Symposium* will be held in Philadelphia, Pennsylvania. Virginia Clower, Jon Meyer and Henri Parens will speak on "The Relationship of Early Development to Gender Identity." Contact Selma Kramer, M.D., The Medical College of Pennsylvania, Department of Psychiatry IEPPI, 3300 Henry Avenue, Philadelphia, PA 19129, tel: (215) 842-4145.

June, 1987

June 5-6: *Harvard Medical School* and *Cambridge Hospital* will sponsor a conference on "Child Psychotherapy" featuring lectures by Stanley Greenspan, Timothy Dugan, Nancy S. Cotton, Jerry Wiener, Sharon Gordetsky, Gerald Stechler and Margaret Frank. Contact Dr. Judy Reiner Platt, Cambridge Hospital, 1493 Cambridge Street, Cambridge, MA 02139, tel: (617) 864-6165.

June 15-19: *The College for Human Development at Syracuse University* will sponsor the eleventh annual Quality Infant/Toddler Caregiving Maternal Workshop at Syracuse University. Faculty will include Alice Honig, John Friedman, Robert Lurie, Donna Wittmer, Susan Untener-Snyder and Maryanne Thiess. Contact Marsha Messer, College for Human Development, Department of Family and Child Studies, Syracuse University, 201 Slocum Hall, Syracuse, NY 13244, tel: (315) 423-2757.

June, 1987

June 22-26: *Erikson Institute for Advanced Study in Child Development* will present its second annual intensive course on child abuse prevention in Chicago, taught by James Garbarino. For further information contact Eva Duncan, Erikson Institute, 25 West Chicago Avenue, Chicago IL 60610, tel: (312) 280-7302.

July, 1987

July 27-31: *The School of Education, College of William and Mary,* and *Child Development Resources* will sponsor their Second Early Intervention Summer Institute in Williamsburg, Virginia, with the title, "Responding to the Challenge: P.L. 99-457." Two content strands will address the Individual Family Service Plan and Team Assessment. For information contact Institute, P.O. Box 299, Lightfoot, Virginia 23090, tel: (804) 565-0303.

July, 1988

July 26-31: The *Second Delphi International Psychoanalytic Symposium* will be held in Delphi, Greece on the theme "Maternal Configurations in Psychoanalysis: Clinical and Cultural Perspectives." For further information contact Mrs. Joe Vile, Symposium Organizer, 33 Price Street, Toronto, Ontario M4W 1Z2, Canada, tel: (416) 922-7770.

Zero to Three is published 5 times per year. Subscriptions costs $15 per year, $28 for 2 years and $40 for 3 years. Subscribers may order additional copies of **Zero to Three** for distribution to staff or students at a rate of $5/auxiliary subscription/year.

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Bulletin of the
NATIONAL CENTER FOR CLINICAL INFANT PROGRAMS VOL. VII, NO. 4 APRIL 1987 ISSN 0736-8083

Call for POSTERS, VIDEOS and SYMPOSIA for NCCIP's fifth National Training Institute December 4-6, 1987 See pp.20-21

Infant Mental Health and Child Abuse and Neglect: Reflections from an Infant Mental Health Practitioner

by
Jeree H. Pawl, Ph.D.
Infant-Parent Program
Department of Psychiatry
San Francisco General Hospital
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The relationship between a parent and a child is crucial to the development of the young child and crucial to the climate in which child abuse and neglect occur. It is the ordinary, everyday experience of the child that is the most salient to his view of the world and to his development. Traumatic incidents happen in the context of relationship; and qualities of a relationship themselves may be abusive or neglectful.

Both infant mental health practitioners and professionals in the field of child abuse and neglect are concerned with the overall quality of the infant-parent relationship. We see a continuum of characteristic qualities, and somewhere on this continuum lies what we conceptualize as abusive or neglectful. In our daily work we encounter, as well, a continuum of services and systems that are designed to strengthen families and protect children. Some of these, unfortunately, might also be characterized as abusive or neglectful.

The infant mental health program which I direct and our city's Department of Social Services have developed an increasingly positive working relationship. We have achieved growing mutual understanding about the relevance of infant health expertise to issues of child protection. Our infant mental health program has also become involved with the court system. These experiences have convinced us of the vivid commonality of concern between the fields of infant mental health and child abuse and neglect. Unfortunately, formal interdisciplinary exchange is rare. The reflections below are an effort to explore how the two fields may aid one another in wrestling with the notion of what constitutes abuse and neglect, physically and emotionally; what can be done to prevent it; and how we can deal with it when it is occuring.

Barbara Young

Common concerns

Infant mental health practitioners concern themselves with both understanding and promoting positive social, emotional and cognitive functioning of infants and toddlers. Child abuse and neglect professionals endeavor to protect children from the unnecessary infliction of pain and cruelty, both physical and, to a lesser degree, emotional.

To both infant mental health and child abuse and neglect professionals, the breadth of complex factors that affect and color the quality of the child-parent

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relationship—which provides the context for both development and for abuse and neglect—is rich and daunting. Obviously, the infant brings her own idiosyncratic self to the situation—a uniquely perceiving and uniquely organized human with strengths and vulnerabilities that are uniquely hers. The parent brings a unique organism and history. Parent and child together will be developing their relationship in a particular nuclear and extended family system, a particular subculture, a unique neighborhood and a certain socio-economic environment. Each of these influences contains its own potential stresses and supports, and these interact with one another in complex ways—ultimately finding expression in the relationship.

In our work with infants, toddlers and their families we see how relationships between children and parents evolve in the context of ordinary, everyday experience. We see strengths and competencies emerge in children and parents and also see insecurities and vulnerabilities, in both children and parents. Most often the relationship will be clearly well intentioned; even so, both children and parents will hurt as well as help each other many times in the earliest years of life. We hope to see a relationship develop that offers the child understanding, mutuality, reciprocity, nurturance, positive regard, safety, concern and protection much of the time.

When child abuse and neglect occur, both infant mental health practitioners and workers in the field of child protection recognize that these do not occur in a vacuum nor do they constitute an aberration, with no relation to the whole range of caregiving. Trauma, as an event and as an organizer, certainly shapes the child's experience, but except at the gravest extremes the context in which trauma occurs is even more shaping.

These insights have found expression in key works of the literature of infant mental health and child abuse and neglect. The volumes *Before, Beyond,* and *In the Best Interest of Child* (2,3,4) speak to the understanding and possible protection of children within the legal system. The work of Kempe, Steele, Helfer, Elmer, Martin (6,11,5,1,7), and hosts of others has equally effectively spoken to the plight of children, and struggled to understand the nature of parental functioning as well as the characteristics of children which may place them at risk. Other workers have argued movingly for the social context of abuse and neglect (8,9). Still, although the basic structure of such a bridge between the two fields exists, the firm connection in the real world between the two fields is often laid and hammered into place by individuals and small service units working essentially in isolation and scattered around the country. The exceptions are wonderful but rare.

This relative paucity of formal interdisciplinary exchange is unfortunate. Understanding infant mental health as having child abuse and neglect within its purview alerts infant mental health practitioners to possible maltreatment which they might otherwise overlook. Further and, more importantly, this conceptualization demands that infant mental health professionals understand how child abuse and neglect are handled socially and legally. Conceptualizing child abuse and neglect as containing within its purview the perspective represented by the field of infant mental

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Robert Maust

health toward the youngest of their population expands the view of abuse and neglect. It demands from professionals concerned with child protection a basic understanding of infant and toddler development and consideration of the nature of relationships. Although a sophisticated approach to the understanding of the complex dynamics of child-parent relationships is reflected in the work of many within the field of child abuse and neglect (10,12), such an approach is insufficiently reflected in the everyday handling of cases. Both fields have much to offer each other.

The experience of the Infant-Parent Program, San Francisco General Hospital.

The Infant-Parent Program which I direct has as its primary purpose working with relationships between parents and children that are seriously awry. Referrals to the program come primarily from sources other than the parent. They include hospital social workers, pediatricians, psychiatrists, Department of Social Services workers, public health nurses and many other professionals who regularly come into contact with infants and toddlers. These professionals become concerned because of vulnerabilities in the parents, direct observations of difficulties between parent and child or concerns regarding the development of the child. The Program is sometimes asked to evaluate and sometimes asked to treat. Treatment is directed primarily at the relationship between parent and child, who are typically seen together. Some families referred may have been reported to the Department of Social Services for alleged abuse or neglect, and in some instances the child may even have been removed from parental care. A reunification effort may be planned, or the Department's intent may be to secure termination of parental rights. Other custody issues may also be a major focus.

The Program's relationship with the Department of Social Services has evolved over time. Initially we had understood our mandate to involve work to improve the relationship between a particular parent and child. Increasingly, though, it has also come to encompass work on behalf of the infant in whatever situation confronts us. In addition, we have provided inservice training regarding the development of infants in the context of their parent-child relationship to those systems which assume the direct or indirect responsibility for infant care.

One of the earliest cases which began to alert us to potential new areas in which our program could have an impact involved a child, Elizabeth. Elizabeth's well-being had been of grave concern to the hospital staff at her birth because of her mother's psychiatric status and her initial refusal to see her baby. The mother refused all services, changed medical providers and was lost to follow-up. At five months Elizabeth was discovered in the wee hours of the morning in a grocery store refuse area abandoned and suffering from severe malnutrition and hypothermia. She was near death. Within a day, her mother attempted suicide and was subsequently confined to a State hospital. All family members were contacted and no one was willing to assume Elizabeth's care. As a result, Elizabeth was placed with a family who agreed to care for her as a foster child but who made it clear that they were eager to adopt if she became free for adoption at a later date. The Infant-Parent Program was immediately asked to work with this foster family around Elizabeth's marked eating disorder and because of the family's voiced concerns about appropriate care for her.

Six months of work consolidated the good beginnings of the relationship between Elizabeth and her foster parents as well as a sense of competency in the foster parents. Yet the ambiguity of Elizabeth's and the foster parents' status continued to be confusing and painful. We remained "on call."

When Elizabeth was 15 months of age, her maternal grandparents, who had never seen Elizabeth, petitioned the court for her temporary custody. They wished not to adopt her, but to assume guardianship. The foster parents were dismayed, as was Elizabeth's social worker. The foster parents wanted to continue to care for Elizabeth and hoped eventually to adopt her. The grandparents in their view, had "missed their chance" over these ten months. They wanted to go to court to fight for the opportunity to keep Elizabeth with them, but they felt extremely discouraged about the outcome.

The report from the local child welfare agency in the city where the maternal grandparents lived was very positive. They were reported to be well-to-do and church going. They even had a swimming pool. The foster parents were lower middle class, with sufficient but limited income, and did not attend church. Neither Elizabeth's social worker nor her foster parents felt that any of these things were the essential issues for the child, but as they had all been highlighted in the Department of Social Services report they felt the court would see them as crucial. Their final concern was that the court, in any case, would "never go against a blood tie" so that any opposition to the grandparents' request would be futile. Our Infant-Parent Program staff was convinced that the important issues were Elizabeth's relationships and her continuing vulnerability. These seemed so important to Elizabeth's well-being that an effort to present this perspective to the court appeared totally worthwhile. We also welcomed the opportunity to educate the court. Even more important, going to court would at least allow the court to actually make the decision. If we hung back, assuming we knew what the decision would be, we would in effect be preempting the court's decision.

After watching Elizabeth with her family, we saw with utter clarity how she was doing. The job of the Infant-Parent Program became that of finding the way to express this voice for her, to bring, first and finally, into the court the person around whom all this tremendous activity actually centers. We are the voice of the infant or toddler who cannot speak for herself and who has no physical presence in the court. We act as a crucial balance to the often poignant and compelling tragedy of the abandoning, neglectful or abusive parent who has persuaded the public defender of the justice of her position and whom the judge sees before her. We deflect attention from the often acrimonious charges and countercharges between competing caregivers, whether private or state, and refocus the attention where it belongs—which is on the *experience* of the infant or toddler. Precisely because the infant or toddler is not physically in the court, he must be there psychologically. Evoking that potent psychological presence is the task of the infant mental health specialist, an awesome but a necessary and rewarding job. In truth, no child should be abandoned to the vicissitudes of the legal system without this representation. That is our most potent contribution, and we must insist upon making it.

Elizabeth's trial was an arduous and lengthy one. We spoke on Elizabeth's behalf as clearly and honestly as we could. Although the infant mental health specialist must sometimes speak in generalities to inform as to development in general, we are truly at our most useful when we know an individual child and family. While we may be relatively ignorant prognosticators, limited solely to our best judgments, we *can* be fully informed of the history of the specific parent and child and of the current situation both through personal observation and interview and careful reading of records. This professional specificity and its translation into the experience of the child is our most powerful testimony. The court was persuaded and it was determined that, until the final disposition regarding her mother's rights, Elizabeth was best served by staying in the world that she knew—one where she was loved, known, and had strong and vigorous relationships. Some time later Elizabeth's mother voluntarily relinquished custody and thanked the Department of Social Services for not disrupting her daughter's care. Adoption by the foster family followed.

We are the voice of the infant or toddler who cannot speak for herself and who has no physical presence in the court. We deflect attention from acrimonious charges and counter charges and refocus the attention on the experience of the child.

The Department of Social Services indicated that the decision was [illegible], and we both recognized that there was a [illegible] role that our program could play on behalf of some of the children we serve. In addition, we were asked to provide [illegible] to the DSS workers in order to increase their understanding of the [illegible] and [illegible] them [illegible] the [illegible] they [illegible].

Ongoing collaboration with the Department of Social Services

As our work [illegible] we find that the perspective of the Infant-Parent Program often influences the outcome of cases which we share with the Department of Social Services. For example, [illegible] was removed from her parents' care at age 21 months.

From birth, Carla had been gravely disabled, physically and cognitively. Over time there had been occasional reports of possible abuse made to the Children's Emergency Service of the Department of Social Services, and recently we had been asked to work with the parents. The most recent report, leading to her removal, had involved some violence between the parents and an occasion on which Carla had been briefly left alone. The DSS social worker felt that Carla's removal was appropriate and saw placement in a group home for seriously disabled infants as an excellent solution for the little girl. The worker from the Infant-Parent Program had seen the family just long enough to have a good sense of how strong and positive a relationship there was between this child and her parents despite the parents' clear limitations and disturbances. The work needed to improve their functioning with one another and their basic skills in caring for Carla would clearly be long, hard and perhaps unsuccessful. However, the moment-to-moment interactions that had resulted in Carla's pleasure in her parents and their pleasure in her seemed vital to preserve and to promise ultimately the best outcome for Carla. In addition to the pain of the loss for both child and parents if removal occurred, any potential for good development that Carla had would be quickly lost in the particular institutional setting under consideration.

As a clinical infant mental health program, our primary effort is working with parents and children in trouble with their relationships. However, infant mental health principles are equally applicable to the issues involved in providing care to children who have been removed from their parents.

Respect for the differing points of view resulted in a meeting where all of the information was discussed and weighed. Carla was returned to her parents. With the cooperation of a number of community agencies, including hard work on the part of the social worker who had initially opposed her return, Carla has remained with her parents much to their mutual benefit.

As a clinical infant mental health program, our primary effort is working with parents and children in trouble with their relationships. When the parent and child come in contact with institutions, however, the infant mental health perspective has an additional vigorous role to play. At almost every point in a procedure involving abuse and neglect of children under three, the input of an infant mental health specialist can be extremely helpful. This is true both on an individual and general level. With a department of social services, for example, information regarding the effects of decisions about shifting a child from one care situation to another may be vital. Moreover sharing the responsibility for a case with a protective services worker adds to the worker's store of information which can enhance his functioning not only currently but in similar future situations. The principles of infant mental health are applicable as well to the central issues involved in providing care to children who *have* been removed from the care of their parents. Training foster care parents, attorneys, judges and other social service personnel; serving on task forces developed to provide group care for infants; consulting on the issues involved in visitation between parent and child all lie clearly within the scope of the infant mental health specialist's expertise. While some of these desperately needed endeavors do occur, they are woefully infrequent and rarely systematized.

Flaws in "the system"

And yet there is more. What has been equally striking as we work at the interface between infant mental health and child protection is the degree to which the flaws, clumsinesses, inequities and even whimsicalities of the system have been revealed. To become involved is to become aware of the serious problems that departments of social services and the legal system face in attempting to carry out their genuine wish to protect children.

As we evaluated the relationship of 21-month-old Henry and his mother, Ms. Martin, for example, it became necessary for the Infant-Parent Program to make a report to the Children's Emergency Services Unit of the Department of Social Services. Some months before, while on the street, Henry's mother had struck her then 15-month-old son across the mouth. He had bled and cried, and she had screamed at him to "shut up." A policeman was summoned, and when he tried to intervene Ms. Martin had assaulted him. One may assault a 15-month-old and get away with it. One may not assault an adult policeman and get away it. Ms. Martin went to jail; she and Henry were separated for 27 days. When Henry was returned to her care, she was assigned a number of tasks. Working with us was among them. Six months later she finally called our program, and we were then in the process of doing an evaluation. Ms. Martin was harsh and abusive with Henry. She pushed him, slapped him and yelled at him unremittingly. When she did not behave fiercely toward him, he was out of control. He could, however, respond to clear and benign limits from the Infant-Parent Program worker.

One may assault a 15-month-old and get away with it. One may not assault an adult policeman and get away with it.

We gradually discovered that Ms. Martin experienced Henry as totally in control of himself and utterly willful if he failed to perform exactly as she wished. We also saw abundant evidence of a thought disorder in Ms. Martin, including her expressed view that Henry was not a human but rather an extraterrestrial being. The most immediate physical danger for Henry was his lack of protection, especially around open windows high off the ground or on busy streets. Ms. Martin reported dreaming that Henry had been killed and then said, "He tried to kill himself twice yesterday by running into the street." She had told him, "You want to kill yourself? Go ahead. I'm not going to stop you." At this point we had no choice, under the child abuse laws in California, but to convey our grave concerns to the Department of Social Services. Their staff felt Henry needed to be removed from his mother, and this was done.

It was at this point that the system began to behave peculiarly. Henry was healthy and had no bruises. Despite having always been described as "wild and out of control," (which was the case when he was with his mother) with the good controls and efforts at reciprocity being provided in his shelter home he was functioning very well. Now there was staff puzzlement as to why this quiet, physically intact child had been removed. The Department of Social Services was now thinking that Henry might be returned to his mother "in a couple of weeks." Only the firmest insistence could persuade the social worker that at the very least Ms. Martin needed a thorough psychological and psychiatric evaluation. What would then happen? No one knew. Why, we wondered, had Henry been removed (in order to protect him) if the result were merely an abrupt separation followed by an equally abrupt reunion, with nothing in between? It was very painful to unleash a series of events over which we had no control and which we could not in any way predict.

We see many cases where removal of an infant or toddler from an abusing home does not quickly provide an appropriate resolution for the child. Children are removed from and then reunited with parents, often with essentially no change taking place.

We see many cases, too, where removal, though protective, does not quickly provide an appropriate resolution for the child. For example, Molly, now 3½, was seriously neglected and finally sexually abused by her mother's boyfriend. She has been in protective custody for 20 months. During the last ten months she has been in a potentially adoptive foster home and has been receiving individual psychotherapy. Neither Molly nor anyone else knows if she will be returned to her mother or when that might be decided. Her mother, who has resided in another state for 18 months, is in a process of "rehabilitation" which may or may not prove successful. It is also unclear who will evaluate the outcome of "rehabilitation" and what it should mean for Molly in any case. All that soothes Molly is some acknowledgment of her ambiguous situation and assurances that "old mommy" will not suddenly appear in any of the concrete situations her therapist can think of to describe. But her ambiguous status is filled with pain, which nothing can truly assuage. Yet Molly is in some ways lucky. The majority of abused and neglected children in similar situations receive no treatment at all.

Children are removed from and then reunited with parents often with no change, essentially, except that a parent has taken a parenting course or secured a temporary job. The main effect of such separations and reunifications can be that strangers now come back together to share a life, that a parent feels abused, and that the child is seen as a proximate cause for those feelings. A child may experience the pain of a new loss—perhaps this time of a relationship with a caregiver that held greater meaning and promise than the experience with the parent. There are other examples of such disarticulations between intake into the social services system and outcome through the courts. A toxicity screening which is positive for drugs in a newborn, is, in San Francisco, considered de facto abuse, and it is unlikely that the infant will be given into the care of her parents. But a grave problem remains. Where will the infant go? Who will care for her? Under what circumstances and when will the infant and parent be reunited? Are they to visit together? Where? How often? Should they be reunited? What factors are considered in making this determination? Who decides? How is all of it handled? Again, one thing seems very clear: the infant mental health specialist can have a meaningful role in all of these processes and decisions, both individually and institutionally. As decisions are made about individual children, infant mental health specialists must represent and express the untenableness of these young children's positions wherever such witness can occur. As workers in insitutions that are part of larger systems struggle to make decisions that are difficult at best, they need to have the benefit of infant mental health knowledge, lest these decisions become virtually impossible. Infant mental health practitioners must recognize that, as painful as it is to be aware of abuse and neglect which a child has suffered at the hands of some other individual, it is perhaps more painful personally to witness further harm to a child as the result of the malfunctioning of a system in which one has some part. Many mental health professionals eschew involvement with institutions for this reason. But our colleagues working within the child abuse "system" can benefit from infant mental health knowledge and involvement. Together, infant mental health practitioners and child abuse and neglect professionals can improve the institutions that affect the lives of children and parents and can improve the functioning of our society.

Adversaries, unclarities, and conflicting values

The very real strains on the system that are produced by impossible case loads and calendars make it easy to view much of the harm done to children as simply the inevitable creaking of a cumbersome system. But in truth the problem goes much deeper. It involves the nature of the judicial system, the unclarities as to what constitutes abuse and neglect, and some serious conflicting values.

Janet Brown McCracken

One of the major impediments to the functioning of the legal system in regard to child abuse and neglect is its adversarial nature. This creates an almost insurmountable obstacle to reaching sane and careful decisions about the most beneficial outcomes for children.

It is the duty, for example, of the parent's attorney in this system specially to "shine up" what may be a totally dysfunctional client-parent for the occasion of a hearing, and to exploit as skillfully as possible the strengths of his case and the weaknesses of his opponents! The department of social services attorney, most usually representing the child, has a responsibility to respond in kind. The judge—seemingly quite alone in what must feel like a trackless waste—seeks precedent, sincerely struggles to understand, and prays not to be reversed.

Responding to such a context, both the social worker from the department of social services and the mental health professional may too often be seduced into "playing the adversarial game." A mental health professional may fail to report a threatening situation bacause his experience indicates that the department of social services is unlikely to respond, in his view, "appropriately." The department of social services worker may gamble on prolonging a procedure indefinitely so that the parent will be " allowed to fail." And so it goes. It is all very human and all happens with the purest of intent on the part of the professionals involved. The opposing attorneys are engaged in "winning," and the other professionals are engaged in trying to engineer outcomes which *they* think will be best for the child. In addition to introducing such whimsicality into so serious a process, such maneuvering makes it less likely that we will come to grips with an even more basic problem.

This is the total unclarity as to what our society wants or is willing to allow in regard to the protection of its children. Ostensibly at least, this society places tremendous value on its children, on the sanctity of the family and on parental rights. These values, however, readily lead to opposing stances regarding child abuse and neglect. In general, society views parental skills as instinctive. We are reluctant to view any parent as incapable of caring for his offspring. In addition, society sees children as the property of those biologically responsible for their existence; the parents' right to treat that property as they see fit is often felt to be inalienable. It is, in fact, true that people within the social services, legal and mental health systems have no right to involve themselves with families uninvited unless there is sufficient concern regarding someone's well-being. Then professionals are obligated to be there. The question of exactly what circumstances should evoke concern sufficient to justify protection and intervention is left extremely unclear, however. This is clearly demonstrated in the courts, where the belief in the over-riding rights of parents is pervasive. The notion that parenthood involves privilege or that children have serious and major rights rarely has primacy in the functioning of the courts.

Because of the adversarial system, these conflicts in values are often not directly confronted but are often obfuscated either deliberately or inadvertently. For example, a dedicated social worker may know that Ms. Trent, a single mother, involved with drugs and seriously disturbed, is consistently emotionally abusive or unavailable to her 18 month old son, Fred. This professional "knows" that the child should not be allowed to grow up in his mother's care as he is already showing marked signs of disturbance and his mother is showing absolutely no signs of improvement despite involvement with a range of services. Fred is taken from his mother's care only after a physically abusive incident severe enough to warrant temporary removal. The social worker believes that his out-of-home placement should continue and that Fred should be freed for adoption. The worker knows that it is unlikely that the juvenile court (particularly Judge Frazer, who is known to "favor parents") would find "in favor of the child." She also realizes, however, that Ms. Trent's life is extremely chaotic and that she has difficulty keeping appointments. The social worker feels that, given enough time, Ms. Trent will become discouraged, leave town and fail to meet the concrete requirements for reunification, resulting in the court's termination of parental rights. The worker bets on the inefficiencies of the system to achieve the outcome she wants. It may be that our hypothetical social worker is correct that Fred should not be with his mother and correct in the scenario she imagines. But the problem is that

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The adversarial nature of the legal system creates an almost insurmountable barrier to reaching sane and careful decisions about the most beneficial outcome for children.

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if the worker fails to inform the court about her genuine concerns, the opportunity to wrestle with the issue of whether or not unremitting, clearly demonstrable emotional abuse is sufficient cause for removal or not is denied to everyone. Fred may be saved some pain but neither Billy nor Monique who are in similar circumstances benefit at all.

We want to protect children but lack clear mandates about what it is that society wishes to protect children from. In California, for example, the laws regarding child abuse and neglect now refer not only to serious physical abuse but also to failure over time to provide adequate food, clothing, shelter, and medical care and to the existence of malnutrition, or non-organic failure to thrive. Child abuse and neglect include, as well, the infliction of mental suffering or emotional harm. All but the latter must be reported to the authorities by anyone in any professional contact with children. This legislation is certain to increase the range of concerns which may lead to a report and possibly even to removal, but the actions that will follow remain uncertain and uncertainty itself is a risk to young children. Thus crowded calendars alone do not keep children in limbo for long periods of time; it is the ambiguity regarding the rights of infants, toddlers and older children which serves endlessly to prolong decisions as to what should happen to children who are presumably "temporary" wards of the courts. There is great reluctance to decide with any swiftness whether a child should or should not be in the care of her biological parents, remain in foster care permanently or be freed for adoption. The confusion over the conflicting values of parental and child rights tends to paralyze courts in their attempts to make decisions. (Again, compounding the problem is the adversarial system, with its own reasons for delaying and continuing. As devastating as these delays are for the well-being of older children who have long-standing relationships with their biological parents, they edge into madness for infants and toddlers, who are, of course, just forming critical relationships. At a time when belonging to someone who cares deeply for your well-being is crucial to a sense of self and other, these children belong to no-one.

It has been my experience that if these basic issues are discussed at all at conferences, whether infant mental health or child abuse and neglect, they are discussed over coffee and in the corridors. They are rarely the subject of discussion of the conferences themselves.

We obviously need ongoing, formal dialogue about what constitutes sufficient child abuse and neglect to warrant institutional interference, both from departments of social services and from the courts. Equally necessary is open discussion about the ways in which the system currently functions and the subversions of the proper functioning of that system. These problems will continue until there are forums dedicated to the careful examination of these issues and problems. The forums should include professionals involved in infant mental health, in judicial procedures, and in child abuse and neglect. Such discussion would help clarify professional roles, help to establish clearer, more open presentation of the issues to the courts, and work toward establishing the parameters of what constitutes abuse and neglect. In addition, such dialogue would serve to open examination of when there should be mandated intervention and how that should proceed. Obviously such discussions cannot set the standards for what constitutes abuse and neglect any more than legislation can. Such views are, first of all, culture-bound, and even within subcultures there are dramatic differences of opinion. But professional dialogue should be a shaping part of the evolutionary process involved in achieving any standards.

If the limited definitions of individual abuse evolve into a consensus about when abuse and neglect warrant institutional intervention, some institutional abuses could be lessened. I would also hope that such efforts would result in increased understanding of the reciprocal reinforcement between personal forms of child abuse and neglect and societal and institutional ones. Such understanding should encourage, in turn, a vigorous political attack on some of the more pervasive and pernicious root causes of child abuse and neglect of all kinds-essentially social disorders. The aim would be correction of problems at all levels in the system coupled with the establishment of comprehensive services readily available at all levels of need.

A touch of class

Finally, it is not possible to work in the field of either infant mental health or child abuse and neglect without becoming aware of one other serious arbitrariness. This involves the question of who comes under the scrutiny of departments of social services and of the courts in general. Clearly it is the people who are dependent upon social systems to begin with. These are also often people who demonstrate most publicly that they have problems, while socioeconomic privilege keeps private the inadequacies of others. These are the people who by virtue of their histories, life stresses and socioeconomic circumstances are most vulnerable to having their life's pain expressed in their relationship with their child particularly in those ways that are most observable. Ironically, our genuine wish to help such families makes it likely that we will lay bare their inadequacies with their children. Of course, situations of pain and poverty do not automatically go hand in hand with inadequate or unconscionably harsh parenting. We can observe this. But we are most likely to become aware of disordered parent-child relationships that occur in poverty, where there is no picket fence to hide behind, no brief case to advertise respectability, no pediatrician to dismiss the injury as accidental, no money to support a drug habit. The drug addiction of a neonate, for example, is far more likely to be discovered and to be reported in a city-county hospital than in a private hospital in a "good" section of the city. We tend to allow observation and intrusion into the lives of those who seem "different" from us

D. Michael Hostetler

but protect the privacy of the lives of our neighbors.

One would not want a policeman to hesitate in arresting a drunk driver because the officer knows that there are ten other equally drunk drivers at the same time whom he hasn't seen. We must insist, though, that this policeman not station himself at Mike's Tavern on the wrong side of the tracks to follow drivers emerging from this spot while neglecting those exiting from his town's fanciest watering hole. The further irony, is, of course, that restricting our vigilance to the poor fails to protect many children and limits the use of our skills on behalf of families across the whole spectrum of society who also need and deserve them.

The issues I have described are of common concern to both infant mental health and child abuse and neglect professionals. We need to deepen and strengthen our links to one another through our professional contacts and in the "real world."

In conclusion, I would like to emphasize again that it is concern for the importance and quality of infant-parent relationships that inextricably intertwines the fields of infant mental health and child abuse and neglect. There is a desperate need for impassioned and open dialogue between practitioners in these fields regarding the issues which are basic and common to them. Together, our efforts might have a significant impact on the functioning of those systems charged with the well-being of children. Together, we may exert greater pressure on social attitudes and policies that harm children of all ages.

I would like to make it clear that the discussions of the difficulties in the system which are designed to protect children are in no way intended as wholesale criticism of those systems or of individuals in those systems. In fact, over-worked, criticized and totally frustrated by the systems as DSS social workers are, they still somehow manage to remain sensitive to, worry about and protect countless children. Day after day they meet the demand to fix the unfixable and manage the unmanageable. I know of no more dedicated individuals. Those in the courts as well struggle with wrenching decisions and do so with great seriousness and responsibility. My hope would be that by working more closely together and by addressing the most basic issues our joint tasks would become more possible. The challenge to better integrate our disciplines is a very exciting one. There are children all over this country who at this very moment are waiting for us to begin.

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Doll Play of Failure to Thrive Toddlers: Clues to Infant Experience

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The experiences of being cared for during the first three years of life are of critical importance to every human being. The interactions of a baby with parent or other primary caregiver in the early months and years have implications not only for the child's developing sense of self and other but also, as leading investigators have suggested, for the individual's later capacity to provide empathic care for his or her own children (Steele, 1980, 1983).

The importance of these early interactions places a heavy burden on those of us charged with evaluation and treatment of abused or neglected infants, toddlers and their parents. Infants cannot tell us about their experiences in words. How, then, can we understand what has been happening in the life of a very young child? In particular, how can we discover the unique meaning that early experiences have had for an individual child?

The play of young children offers us many clues about their inner worlds. When the authors watched toddlers who had previously been diagnosed as failure to thrive playing with dolls we observed fascinating reflections of the children's earlier experiences and, in some cases, of their mothers' early experiences as well. The dramas we watched were played on stages that seemed to be set for repeated tragedies—unless cycles of abuse could be interrupted by appropriate treatment for mother and children.

Before presenting case vignettes of three such children, we should note that an infant's poor physical growth—in these cases, severe enough to be diagnosed as failure to thrive—is often the first unmistakably observable sign of disturbances in the mother-infant relationship. Treatment of failure to thrive provides an early opportunity to modify the infant's experience with a primary caregiver. Our observations of toddlers who had been previously evaluated with their biological mothers illustrate the consequences of *failure* to alter the vulnerable infant's experience. In each of the following cases, the toddler was observed playing with a doll in the presence of a mother or mother figure one year or more following a diagnosis of failure to thrive. Throughout the evaluation session, the toddlers' attention was focused on nurturing their dolls; their manner of doing so, we believe, reflected their own experiences of being cared for by their biological mothers.

Lara and Lisa

Differences observed in the doll play of 20-month-old identical twins diagnosed as failure to thrive at 3 months of age were both intriguing and puzzling. These two toddlers had been born into the same environment and raised by one mother, yet their individual experiences during their first 20 months must have been markedly different. In the presence of her mother, Lara repeatedly fed her doll by placing the doll bottle between the doll's legs. This unusual behavior was not observed in her sister, Lisa. The girls' mother had herself been sexually abused as a young child by her stepfather, and the possibility that Lara was being sexually abused was one explanation for her unusual behavior with the doll. A more careful review of the videotaped interview and interactions suggested another plausible explanation.

Infants cannot tell us about their experiences in words, but their play offers us clues about their inner worlds. When we watched toddlers who had previously been diagnosed as failure to thrive, their play with dolls reflected their earlier experiences of being cared for.

What became increasingly apparent in viewing the videotape was that Lara and Lisa had very different patterns of interacting with their mother. Lisa's behavior was more consistent with a healthy attachment relationship with her mother. She felt secure in her explorations and approached her mother less frequently than did Lara, engaged her in face to face social interactions, and was more successful than Lara in having her mother comply with her wishes. Lara, in contrast, would back into her mother's lap and sit with her own nursing bottle in the mouth while her mother stroked her thighs and buttocks without seeming to pay attention to her. The mother also responded differently to the same request from the twins. When Lisa approached her mother and requested that she wrap her doll in a blanket, the mother complied with her wishes. Lara approached with the same request only a few seconds later. The mother ignored her request and instead placed her in a supine position on the floor to change her diaper. Lara's attempt to elicit her mother's attention by engaging her in play with her doll had resulted instead in interrupting her play and drawing mother's attention to her diaper, the same area of her body that Lara was observed attending to with her doll.

Lara remained in her diaper while Lisa, whose diaper was never checked throughout the two hour session, was fully dressed. A second diaper change near the end of the session provided further insight into the meaning of Lara's unusual behavior with the doll. After removing Lara's diaper, the mother began to tickle and play with her as she lay in a supine position on the floor. The diaper change was mutually pleasurable and during their play Lara experienced her mother's attention and availability. Having observed her previous unsuccessful attempts at engaging her mother in play with the doll, we could understand Lara's reluctance to let go of this experience. When her mother completed the diaper change and requested her to get up, Lara remained motionless on the floor. Her mother had to pull her to an upright position.

In her play with her doll, Lara repeated her own experiences of being nurtured by her mother. Lara was doing to her doll what had felt good to her. Her focus of attention was not to the doll's face, but between the doll's legs and toward the doll's buttocks. While Lisa would carry her doll in an appropriate manner, with attention focused toward her dolls' face, Lara would carry her doll upside down and backwards, focusing her attention toward the doll's buttocks. The doll play of both children reflected how vastly different their experiences of being nurtured had been during the first 20 months of life. Sexual abuse had in fact played a role in the development of the interactions being observed, but not in the manner that we had originally hypothesized.

We learned that the twins' mother had experienced sexually abusive attention from her stepfather and had not resolved what her own role might have been in that relationship. Her conflicted feelings about the lack of control she had over her body while being simultaneously victimized and nurtured were reflected in her description of her recurrent dreams: "I have terrible dreams...being in a jungle gym and trying to get out, I just keep running into the bars and I can't run, it's just like being paralyzed, I couldn't get my body to do what I wanted it to do." Now these conflicts were leading to repetition of her experiences of attention to the genital zone in interactions with Lara, who was herself repeating experiences with mother in interactions with her doll.

Annie

When 19-month-old Annie was reevaluated with her mother we became aware that her doll play reflected what had been previously observed in her mother's interactions with her just one year earlier, when Annie was only 7 months old. At 19 months of age Annie was not able to feed her doll. She repeatedly interrupted her action of moving the bottle toward the doll's mouth. At times she would scream at the doll and hit it hard enough to knock it to the floor. She would then pick the doll up, hold her *en face*, and talk softly to her as if apologizing for her harshness towards her. Throughout the session she moved the doll from place to place about the room as if searching for a good place to feed her. When she was able to concentrate long enough to feed the doll, she did so by placing the bottle directly onto the doll's stomach or into the doll's hand. She was never able to feed the doll with the bottle to the doll's mouth.

This pattern of interruptions in feeding looked uncomfortably familiar. When Annie and her mother had first been evaluated twelve months before, the mother ignored Annie's signals of hunger even while she held her in her lap. Annie's stress would escalate to a cry before her mother pushed a pacifier into her mouth. When Annie released the pacifier and continued to fuss, her mother responded with, "Yes, I know you're tired." The mother did not agree to feed Annie until the evaluator, herself uncomfortable with Annie's unanswered cues of distress, suggested that perhaps Annie was hungry. A prolonged period of locating the bottle in the diaper bag and situating Annie in a reclined position for feeding preceded the movement of the bottle toward Annie's mouth. Annie was just about to receive the bottle when her mother abruptly interrupted her action and accused Annie. "I bet you did, yeah, you got me wet, you little turkey, okay we'll change you." After what seemed like an interminable period of undressing, changing, and redressing Annie, her mother was finally ready to resume the feeding. As she placed Annie in the reclined position, she announced her intention to feed, "Okay, I'll feed you if I can find your bottle." Annie finally received the bottle and was sucking, with her attention focused on her mother in a watchful way, when her mother looked at her and in a soft voice said she was sorry but she had to change her.

Barbara Hadley

The mother's own reports of Annie's early infancy confirmed the occurrence of this pattern even before Annie was first evaluated. She recalled propping Annie's bottle for feeding because she herself always had diarrhea when she held Annie to feed her and had to stop the feeding to run to the bathroom. This same pattern of offering and withholding food was observed again in the session when Annie was 19 months old. The mother extended a bag of chips to Annie who initially hesitated to reach for it. Just as Annie reached for the chip, her mother withdrew the bag out of reach and took a chip for herself before again offering the chip to Annie. Later in the session, Annie hid behind her mother to eat the chips. When her mother turned and spoke to her, Annie's hunched posture and distressed facial grimace clearly showed the anxiety she felt when her mother discovered her eating.

Annie's mother's description of her mutually rejecting relationship with her own mother fit the relationship we observed between her and Annie: "She never liked me, I never liked her, it worked both ways." Like Annie, she associated her mother's attention with feelings of anxiety and tension: she believed her mother enjoyed her pain and encouraged her younger brother's aggression to her. She and her brother were not allowed to have a positive relationship and got into trouble if they were "caught attempting to play." The inadequacies within the family carried over to her relationships outside the family. She summed up her experiences with peers in a pathetic way: "Nobody ever played with me when I was little: I'm used to it." Unloved by her mother, she had internalized a poor sense of self and distrust of others. She could not give to Annie what she had not received for herself. Although she wanted affection which she had never had, her distrust of others' motivations, including Annie's, interfered with the development of positive relationships. For example, when the evaluator commented on Annie's smile, the mother warned her to watch out for Annie's teeth: the message was that this 14 month old could not be trusted and that her friendly appearance was deceiving.

Lucy

The connection between the doll play of 29-month-old Lucy and her earlier experiences of being nurtured by her biological mother was astonishingly clear. When Lucy had first been seen with her teenage mother at 8 months of age her emaciated condition was a visible sign of the starvation she had already experienced. Twenty-one months later we watched as Lucy did to her doll what we had observed her biological mother do to Lucy. Lucy, who had since been relinquished by her biological mother, entered the room with her adoptive mother and immediately picked up the doll. She gently placed the doll on the floor, searched for the bottle, and leaned over to feed the doll. Seconds later she removed the bottle, but returned it to the doll after her adoptive mother asked, "Are you going to feed the baby?" The pattern was repeated as Lucy returned the bottle to the doll's mouth and again removed the bottle within a few seconds.

The connection between Lucy's present actions and her past experiences of being nurtured became even more apparent when she repeated the same words her biological mother had said to her in the evaluation 21 months earlier, when Lucy was only 8 months old. "Gone, all gone," said Lucy. The first time we had heard those words we were observing the infant Lucy being fed by her mother. Lucy rapidly finished 4 ounces of milk. Lucy continued to suck on the empty bottle until she fell asleep in her mother's arms with the bottle still in her mouth. Rather than gently removing the bottle to avoid awakening Lucy, her mother startled her by pulling the bottle out of her mouth and repositioning her into an upright sitting position. Lucy reached for the empty bottle that was now within grasp in her mother's hand and tried to bring it closer as her mouth gaped open like the beak of a little hungry bird. Lucy was finally successful in maneuvering the bottle into her mouth, but her mother removed it again shaking it loose from Lucy's hands with, "empty, empty, all gone, all gone." A few minutes later, the mother repeated those words as Lucy struggled hopelessly to get the nipple back into her mouth. Now, 21 months later, Lucy repeatedly put the bottle in the doll's mouth and removed it within seconds, each time saying, "gone, all gone."

To keep the cycle of abuse from continuing from generation to generation, we need to change the infant's experience with the primary caregiver. The therapeutic process will hopefully provide the vehicle for the mother to deal with conflicts from her past, thus freeing her to care for the infant appropriately.

Lucy's mother had revealed little about her own childhood except that her parents had divorced when she was young and she and her siblings had been left with the father. She was celebrating her sixteenth birthday the day she was evaluated with Lucy, but expected no one in her family to remember the occasion. Her own experiences of emptiness and deprivation were reflected in her interactions with Lucy: she had never been filled up and could not fill up Lucy. She summed up her own experiences as well as Lucy's with the words, "You can feed her and feed her and feed her all day long but she'll still want more and more and more."

Discussion

The failure to thrive infants' mothers in these vignettes each seems doomed to repeat her own experiences of being cared for in her earliest years. Unless the pattern of interaction is modified by appropriate treatment of the mother, which then modifies the infant's experiences of being cared for, the cycle of abuse is apt to continue from generation to generation. Although the processess which account for the repetition of experiences of being cared for in infancy are unclear, the phenomenon of repetition has been described. Fraiberg, Adelson, and Shapiro (1980) characterized the influence of the past in the present as "ghosts" from the mother's conflicted past which invade the nursery. They described mothers who had been inadequately nurtured themselves as infants and who were unable to provide empathic care for their infants. The infant evoked unconscious memories of the mother's own experiences in infancy, and these experiences were reenacted in "exacting detail" until, with the help of the therapist, the mother was able to attach affective feelings to her experiences. She was then able to empathize with the infant and to respond to the infant's signals without the interference of the "ghosts" from her past.

Buxbaum (1983) described the vulnerability of mothers and infants in terms of "unconscious bodily memories" of being fed, held, and cared for in infancy. In a case reported by Engel and Reichsman, (Buxbaum 1983, p. 92) "Monica" was born without an esophagus and fed as an infant by tube directly to her stomach. As a mother she was observed placing her baby on the bed to feed her without cuddling. When asked about this behavior, Monica said the baby was more comfortable being fed this way. In a case reported by Elsie Broussard, (Buxbaum, 1983, p. 92) a mother was observed to hold her baby stretched out in her arms in a peculiar way. This mother had been in a body cast as an infant and was holding the baby as she had been held. In each of these cases, the mother was unconsciously repeating her experience of what she felt when being comforted and nurtured during infancy. Buxbaum explains the mother's behavior in terms of body memory: "the mother's unconscious bodily memories are revived by the infant, so that the mother does to the infant what she has kept as a memory in her body but does not remember consciously." (p. 92)

Our own observations of Lara and Lisa, Annie and Lucy suggest that toddlers' unconscious memories of their mother's attention may be revived by dolls in the presence of nurturing figures. The toddlers repeated mother's behavior to them in "exacting detail" in behavior with dolls, had attended to the dolls in the manner in which they had themselves received attention in the past. Annie and Lucy had not been fed by their mother since the initial videotaped feeding and presumably had received adequate nurturance from foster mothers. Even so, they were preoccupied with feeding and seemed compelled to repeat the inadequacies in their own experiences of being fed in the first months of life. Lara's attentional focus on her doll's genital zone showed the unusual consequences of her experiences with a mother who had unresolved conflicts about her own victimization. It is important to note that while we have focused in this paper on doll play of girls, our observations of boys' behavior to dolls also show significant effects of early experiences, albeit in a different form.

To interrupt the generational repetition of unempathic care and poor attachment between mother and infant, we need to change the infant's experience with the primary caregiver. The interactional assessment procedure (Haynes-Seman and Hart, 1987) used in the cases presented here delineates the specific disturbances in the relationship that need to be resolved. Focused psychotherapy, for mother and infant, begins with good clinical interpretations of videotaped parent-infant interactions; it also includes interviews with the mother about both her experiences with the infant and her own experiences as a child. The therapeutic process will hopefully provide the vehicle for the mother to deal with conflicts from her past, thus freeing her to respond more appropriately to the infant as a unique and separate individual. If the infant cannot be safely maintained or reunited with the parents or if a healthy relationship cannot be achieved within an appropriate time frame for the infant, the infant needs to receive empathic care from an emotionally invested caregiver. Even adequate care from a foster mother, if the foster mother has no special attachment to the baby, is not enough to prevent the repetition of the infant's experiences of poor nurturing in the next generation. To help infants at risk for loss of mother on a large scale, we need to alter the present system of permanency planning and develop more responsive foster-adopt programs.

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The **National Committee for Prevention of Child Abuse** publishes a wide variety of booklets on child abuse, child abuse prevention and parenting designed for the general and professional reader, for parents and for children. These include a 16-page *Resources Directory* listing national resources and information on locating facts and services in the child abuse field. *Emotional Maltreatment of Children*, a 30-page booklet by James Garbarino, president of the Erikson Institute for Advanced Study in Child Development, and Ann Garbarino, is available in a newly-revised edition. The booklet defines and illustrates types of emotional maltreatment and suggests strategies to prevent and deal with the problem, particularly the social isolation in which emotional maltreatment typically occurs. *Parent-Child Bonding: The Development of Intimacy* by Stanley I. Greenspan is a 10-page pamphlet in question and answer format. It suggests that "parent-child intimacy" may be a better term than "bonding" and also recommemds sources of assistance if parents are concerned about their relationship with their infant.

A catalog of publications is available from the National Committee for Prevention of Child Abuse (NCPCA), 322 South Michigan Avenue, Suite 950, Chicago, Illinois 60604-4357.

Abuse and Neglect in the Earliest Years: Groundwork for Vulnerability

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The maladaptive human behaviors which we subsume under the title of child abuse have existed since the dawn of recorded history. We speak of it as biologically maladaptive because those caregivers or other adults who should be providing the best possible care for human offspring instead exhibit acts of commission or omission which interfere with the optimal physical, emotional and cognitive development and growth of those children who will be the next generation of adults. It is largely in the 19th and 20th centuries that much attention has been paid to the problem, and it is particularly in the last three decades that the magnitude of the problem with its tragic consequences has been more fully recognized. This has led to increased efforts to develop means of helping both victims and perpetrators. Child abuse is widespread throughout the world and occurs in all socioeconomic and racial categories although it varies in different settings and in different cultures. We do not have any accurate statistics about how much maltreatment of children there is at present nor any good information on how much there was in the past. So we can make no valid statements about any recent increase or decrease in the phenomenon. We do know, however, that any at all is too much.

Although we know that maltreatment has existed throughout man's history, we also are aware that there have been efforts throughout the centuries to care for unfortunate children. In the past such efforts have been primarily directed toward the rescue and provision of care for abandoned, starving, wandering, homeless and orphans. Shelter and food were provided predominately by religious organizations, private charities and government. Social service agencies were the mainstay of care with special orientation toward problems of neglect. During the recent three decades the medical profession has become increasingly involved and has drawn attention to the serious problems of the battered child, failure to thrive, and sexual abuse that exist in addition to the more obvious problems of gross neglect. The legal profession, too, has become increasingly aware and involved in the existence of the problem and the complexities of its management. There have been new laws enacted in the children's codes of the various states and an increasing awareness and knowledge of maltreatment with the development of new standards in the judicial system of handling the growing number of cases brought to their attention.

There are two main and very good reasons for our concern about child abuse. Of prime importance is our wish to minimize and eventually eliminate the physical pain, emotional anguish and deprivation of abused children and to provide the best possible chance and means for their growth and development toward normal, healthy living. In addition to this humanitarian desire to care for each individual hurt child, we have become increasingly concerned about the effect which child abuse has upon the fabric of our society in general, and the unnecessary burdens that it places upon all of us.

The most serious and long lasting effects of maltreatment follow significant neglect and abuse during the first three years of an infant's life. Some harmful effects of the maltreatment are evidenced immediately in the life of the infant and growing child. Other sequelae become apparent only after many years, coming to the surface in adolescence and adult life. Many children subjected to only isolated, nonrepeated episodes of abuse, or who have had extensive experience with good caregivers, grow up to be essentially healthy "normal" adults. Infants who have had brain damage due to head trauma may show significant neurological deficits and mental retardation and spend the rest of their lives in institutions. Less severely neglected or abused infants may show deficits and delays in motor development, language development and social skills, and show various learning difficulties. They often require special education help. The school system is usually unaware of the abusive background origin of the behavioral and learning difficulties of these children.

The most serious and long lasting effects of maltreatment follow significant neglect and abuse during the first three years of an infant's life. The unempathic, neglectful, abusive caregiving experience of early infancy leaves the child with a poor sense of self, a shaky identity, a lack of basic trust in people, difficulty in finding pleasure, a propensity for depression, fears of intimacy, and long lasting feelings of emptiness and dependency.

The unempathic, neglectful, abusive caregiving experience of early infancy leaves the child with a poor sense of self, a shaky identity, a lack of basic trust in people, difficulty in finding pleasure, a propensity for depression, fears of intimacy, and long lasting feelings of emptiness and dependency. In varying degree, all of these will have a deleterious effect upon the child's ability to grow and to develop satisfying human relationships in adult life.

One of the more striking phenomena seen in the child abuse spectrum is the generational repetition of maltreatment. Almost without exception those caregivers who neglect or abuse children were, themselves, victims of significant neglect, with or without physical abuse, in their earliest years. Like language, basic patterns of parenting are learned in a setting of the earliest interactions between infants and caregivers. Good parents, as well as those with impaired parenting patterns, repeat with their own offspring the ways in which they themselves were brought up in early years. While there may be some biological, instinctual drive toward becoming a parent and caring for offspring, the actual pattern of the parenting is determined for both men and women by the experiences of being parented in the first months of life.

Although many things happen to people besides the experience of being cared for well or poorly in the earliest years of life, there is increasing evidence that the experience of being neglected or abused in earliest years provides fertile soil in which many other difficulties can take root and grow. Careful life histories taken of juvenile delinquents indicate that nearly all have experienced significant neglect or abuse in their lives. Most runaways are trying to get away from situations of maltreatment, and many runaway girls are trying to escape from incest. With few exceptions the major criminals inhabiting our prisons have a history of juvenile delinquency and hence of early life maltreatment. The enormous number of sexual offenders seen in our courts and in our prisons routinely give a history of having been sexually abused in childhood, with such events being unrecognized and uncared for. A high proportion of the patients in our psychiatric clinics and mental health centers and psychiatric hospitals give a history of having been significantly neglected and physically or sexually abused in childhood. As many as two-thirds of the women seen in battered wives shelters have a history of being victims of incest. Nearly all juvenile prostitutes, both boys and girls, have come from an environment of neglect and sexual maltreatment.

It would be an exaggeration to say that all of these personal tragedies and burdens on society are simply due to child maltreatment. Yet it is impossible to disregard the accumulating data which indicate that unempathic, neglectful, abusive care in early life hampers a child's growth and development and increases his vulnerability and susceptibility to many of the other problems and difficulties encountered in life.

The maltreatment of infants and children creates an enormous amount of individual human suffering and damage, and the ramifications of such maltreatment in later years places an enormous emotional and financial burden upon society in general. Until fairly recently we have put most of our efforts into picking up the broken pieces of human lives and trying to put them together, a difficult and endless task. There is great need to further develop our knowledge and already existing abilities to prevent maltreatment by providing more appropriate and better services to help young parents to more happily and successfully care for their offspring in the first three years of life. It behooves us all to work for this crucially important function in our society.

Psychotherapy of the Violent Offender: A Recapitulation of Infant Development

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His father was an abusive alcoholic, his mother chronically depressed. Because of their abuse and neglect, he was taken from his parents and put in a foster home when he was eight months old. He went through seven foster placements in the first six years of his life. He was described as impulsive, distractible, hyperactive, "wide open." He failed second grade; when he failed eighth grade he left school. He was an alcoholic by age 12 and in and out of training schools for breaking and entering and for larceny. He is now serving a life sentence for murder.

This story is typical of the lives of the maximum custody violent offenders with whom I have worked over the past five years at North Carolina's Central Prison. In my psychiatry clinic I see men, serving life sentences or living on death row, who are dangerous and thought untreatable. Yet I have seen such prisoners respond to therapy. And the therapeutic process which I have watched unfold (in more than 1600 patient contacts with 125 prisoners last year) strikingly resembles the stages of infant development described by Stanley Greenspan (1981).

Four stages in the process can be distinguished in the primary corrective experiences these patients need: 1) re-establishing homeostasis; 2) establishing attachment; 3) beginning purposeful communication; and 4) organizing behavior.

Re-establishing homeostasis

Maximum custody prisoners usually come to the prison emergency room or psychiatry clinic with state regulation problems. These may include poor sleep/wake cycles, lack of interest in the world, hyperactivity or lethargy, fluctuations of weight, and hypersensitivity to noise—symptoms not unlike those seen in infants whose development in the first months of life is disturbed. Like infants, these prisoners often respond to straightforward state regulation interventions—structured sleep time, exercise, interesting activities, even warm milk at bedtime. Such interventions often eliminate the need for traditional approaches to treating depression. Warm milk may be effective for sleep problems because of the sedative effect of the L-Tryptophane it contains. I suspect, however, that inmates need concrete "feeding" as well; benign medications, milk and even special diets provide a medium with which these patients can engage.

Establishing attachment

Forming a specific relationship with the therapist—very much like that between the infant and the primary caregiver—may begin almost immediately or may take a prisoner many months or even years. The length of time needed seems to depend on the presence, if any, of strong attachments in the prisoner's earlier life. Regularity of contact and the dependability of the therapist help the inmate to experience the therapist in a new way. The relationship begins to matter, and to regulate the inmate. Medications at this stage can be a "transitional object," a reminder several times each day of the therapeutic relationship and what it has come to mean to the prisoner.

Beginning purposeful communication

Inmate patients are often surprised that promises to them concerning therapy are kept—that, for example, they are brought back to the clinic on schedule, again and again. They often ask for something on every visit—an adjustment in medication or more frequent appointments, for example—and are surprised when agreed upon changes are actually made. Predictability, regularity and responsivity to their specific needs are often new and unique experiences in their lives. These experiences may enable inmates to learn new ways to ask for help: many progress from seeking attention by self-mutilation or fire setting to writing notes to the therapist in times of crisis, requesting help.

Organizing behavior

Once the relationship is in place and important to the patient, he beings to fear the loss of the therapist's approval. In the closed prison environment, the inmate knows that the therapist will learn of most behavioral problems, and that he will have to talk about this behavior when he sees the therapist. Now the inmate—like the preschooler—can internalize the therapist in the form of adaptive assertive behaviors. The inmate begins to negotiate and verbalize, rather than acting out. Some patients can replace seeking approval from the therapist with seeking approval from themselves. Some may be able to participate in more traditional insight-oriented psychotherapy. Most continue to need therapeutic support. As one inmate put it, "If you have a firm shoulder to lean on, you can make it. If that shoulder falls, you fall too."

Comment

When we fail to provide functional and caring primary relationships to infants and young children, we may find ourselves having to provide similar relationships to adults, but this time to adults who have been unable to live in society and who have suffered—and caused—incalculable damage.

Three days before his death, a man who was to be executed for a brutal murder told me, "All a young'un needs is love, someone to be there for him, to care about his problems. If he has that he can make it." My work with maximum custody violent offenders has convinced me that it is never too late for human beings to benefit from such caregiving. But I am also convinced that it is a lot easier to provide for the infant at risk than for the violent offender on death row.

Special thanks to Lou Ann Brower for her very helpful guidance and encouragement in preparing this manuscript.

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Perspectives on Practice

The Effectiveness of Crisis Intervention in Working with a Young Mother and Her Four Pre-School Children

by
Sarah Landy
Beechgrove Children's Centre
Kingston, Ontario

Interventions made when crises occur can result in dramatic, catalytic shifts in insight. For Kaye J. these moments, embedded as they were in an ongoing, stable range of interventions, resulted in sudden self-understanding and marked improvement in aspects of her relationship with her children.

It is not the intent of this case report to describe either the process of our work with Kaye and her children or the dynamics involved in any depth or breadth. I wish rather to highlight the efficaciousness of "being there" in moments of crisis and what this may accomplish.

A child protection worker referred Kaye, age 22, and her children—John, age 5; Mike, age 4; Jane, age 2; and Paul, age 3 months—to our infant center. The worker had just returned the children to Kaye after their sixth experience in foster care within a year. Mike was described as "out of control" at four years of age. In the past five months he had been expelled from three day care centers because of his behavior. He had set two fires at home and exhibited both self-abusive behavior and random, unprovoked aggression toward animals, siblings and other children. The worker said that Kaye appeared to care about her children but neglected them when she became depressed after

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This article describes the author's work at the Merici Centre, Regina, Saskatchewan, an infant center providing a wide range of services for children from birth to three years of age and their families. Many cases are referred for abuse and neglect and the center provides home visiting and in-center programs.

Barbara Young

alcohol or drug abuse. She sometimes abused two-year-old Jane.

We arranged for the social worker to bring Kaye to the center's Christmas party so that she could meet us and make an appointment.

At the Christmas party, apparently uncertain about what to do, Kaye stood on the stairs holding the baby Paul while the three other children hid behind her. When two-year-old Jane lost her grip and fell down the stairs, Kaye exploded into laughter as the little girl lay at the foot of the stairs crying pitifully. The two older boys quickly joined their mother in ridiculing their sister. (Kaye later told us that she herself had fallen downstairs at the age of three. Instead of offering comfort, her mother had laughed and told her not to be stupid. After Kaye had been in intense pain for several days, it was found that her arm was broken.)

We scheduled a home visit for the following week. A process of assessment began that included home visits, which allowed us to observe the family under typical conditions, to evaluate the children with standardized instruments and in play sessions, and to videotape sessions illustrating Kaye's reaction to each child as well as family interactions. All of the children tested in the range of 110-120 DQ or IQ, and the older children showed adequate language and conceptual development. Although terrorized by his younger brother, five-year-old John assumed caretaking responsibilities for his younger siblings and, at times, tried to comfort his mother. Mike taunted, teased, stole toys, and created a whirlwind of devastation: his fury united the rest of the family in a bizarre way as they lamely protested. Two-year-old Jane seldom sought Kaye's affection or used her mother as a source of approval, comfort or organization. Kaye herself—reared in a severely alcoholic, neglectful and at times abusive family—was a depressed, generally helpless bystander in family interactions. Occasionally she responded warmly to the infant Paul, and at times reacted to her children if they actively sought her participation in play.

Although all three older children showed signs of distress, our principal concerns centered around Kaye and Mike and the effect of their behavior on each other and the family. With her alcoholism, drug dependency, poor identity integration and transient psychotic episodes, Kaye seemed best described as having a borderline personality syndrome. Strengths included her above-average intellectual capacity, her eagerness for treatment, and her partial recognition of her tendency to seek any available satisfaction for her dependency and nurturance needs. She viewed her baby and her therapist as a "rebirth and a chance to do things better." But Kaye also needed to "feel her way" through a situation or relationship; she had difficulty conceptualizing experience beyond a very concrete level and transferring it from one situation to another.

Interventions—planned and unplanned

In the course of discussions with Kaye, we decided on a format of psychotherapy twice a week for Kaye and play therapy once a week for Mike. A volunteer was available to care for and interact with all the children during Kaye's sessions. A graduate student in social work visited the home three times a week for about an hour to demonstrate parenting skills and to help Kaye with problems of everyday living. In addition, a male and Kaye's female therapist held weekly play sessions with the family. Videotapes of these sessions were used to illustrate for Kaye the children's needs, difficulties and interactions. Kaye found it painful to review the videotapes at first, but as her ability to interact with her children in the sessions gradually improved Kaye would proudly identify moments of appropriate interaction and mutuality.

Four therapists—professionals, trainees and volunteers—were involved with Kaye and her four children in more than seven scheduled encounters each week. Kaye also participated in various group sessions and workshops at the center. It is important to recognize that families such as Kaye's require huge amounts of time and energy devoted to them; no less important is the fact that such a level of effort would be impossible in most mental health agencies.

Kaye progressed slowly through her therapy and family sessions, but remained emotionally unavailable to her children. She seemed to need more than the organized sessions provided. A shift came in the form of several critical crisis interventions in which insight and understanding seemed to hit Kaye like a lightning bolt.

The first drama unfolded around Kaye's paranoid schizophrenic brother, who had moved into her house and refused to leave. Kaye sympathized strongly with his suffering. She refused to recognize that a young man hallucinating regularly, brandishing knives and at times becoming violent was a threat to herself and her children, even though center staff had to summon the police after Kaye called to say her brother had wounded her. As she cried about her failure to help her brother, she remembered for the first time the nightly attacks on him by her alcoholic father. She expressed anger at her father and sadness for her brother, and for the first time assumed a more protective stance toward her children.

Her brother's departure left Kaye depressed, and she slipped more and more into alcoholism. Late one night, Kaye called on me (her individual therapist) to deal with the police who wanted to arrest her; driving while drunk, she had been involved in an accident that seriously injured the other driver and she had left the scene of the accident. I persuaded the police to let her stay home and promised she would appear in court the next day. I arrived early the next morning to drag her, sick and sorry, from bed, and I insisted that she call the Alcohol Rehabilitation Center to arrange to enter a detoxification program. Months later, Kaye stated that this had been a turning point for her. Although part of her hated me, she understood that she needed my demand in order to force her to take this step.

On another occasion Kaye called late at night, seriously depressed. Paul had just started to walk. When I entered the house that night I found Kaye curled in a ball on the couch rocking a doll in her arms. She said she felt sad, lonely and abandoned. Suddenly she became aware of the doll in her arms and asked, "What am I doing?" I turned the question back to her and she described her feelings about abandonment and the possible reasons for this sensation of loss. She quickly realized that she was mourning Paul's arrival at toddlerhood. She was yearning for the feeling of nurturance she experienced when holding a tiny baby. Together we recognized how she had always become pregnant soon after one of her babies walked. She became aware that again she had stopped taking birth control pills and felt alarmed and relieved at her realization that she had narrowly missed becoming pregnant again. We slowly explored what toddlers meant to her and searched for some pleasures she could take in her children's development.

Crisis interventions sparked by Kaye's relations with men also provided sudden understanding of her severe problems in that area. Several times during treatment, Kaye found new male companions; each one, she hoped, would be the "perfect man." Instead, these alcoholics or drug pushers took Kaye's money, used her sexually and abused her. None stayed long enough to integrate into the treatment, but incidents that required my intervention provided rich material through which Kaye could explore her tendency to see people as "all good" or "all bad," her ambivalent feelings about men and her hitherto unconscious need to be victimized by them.

Discussion

As one part of a wide range of treatment modalities, crisis intervention provided vital opportunities to share and understand Kaye's pain in the moment, to demonstrate concern, to bring insight to and confront the most salient treatment issues. Because the crisis interventions occurred as the result of real, current situations, Kaye could not as readily deny or avoid her precarious existence. The dramas that were enacted in our presence were replayed and reviewed time and time again in therapy sessions that followed.

For many abusing and neglecting mothers, such concrete, reality-oriented interventions may be a necessary part of any range of treatment modalities. For such mothers, crisis, violence and upheaval seem inevitable and perhaps even sought after. Being there in those moments, entering their reality, and then stepping back together to understand them, provide a powerful tool for strengthening ego functioning and for growth.

Postscript

When our involvement with Kaye and her children began, she described her feelings this way: "I can't stand being around the children, because they remind me of me as a child ... I want to run away and start over ... to do it better and be a better person ... I sometimes dream that I'm flying away and free...."

At Christmas, the fourth anniversary of our first meeting, I received a card from Kaye. She is studying criminology at the university and plans to work in the penal system. The note was brief but encouraging: "I miss you all but can't afford to get home this Christmas. I hoped we'd be able to surprise you all at the Christmas party, where we began ... you'd never recognize the children, they're so grown-up, and, speaking of grown-up, that's the way I feel ... most of the time anyway ... at last."

National Center Notes

by Eleanor S. Szanton

Ten years ago, a few leaders in the field of infant health, mental health and development, meeting at a professional conference, got into deep conversation about what was needed to promote better public understanding of the importance of the earliest years of life. They hit upon the idea of founding an organization to begin to address these issues. Berry Brazelton, Selma Fraiberg, Stanley Greenspan, Ronald Lally, Bernard Levy, Reginald Lourie, Peter Neubauer, Robert Nover, Sally Provence, Julius Richmond, Albert Solnit, and Leon Yarrow formed that organization—the National Center for Clinical Infant Programs—, and they found a few thousand dollars to incorporate it. Our debt to the founders is great. We miss those who are no longer with us.

From those modest beginnings, NCCIP has grown, expanding its Board to reflect an increasingly multidisciplinary scope, and developing national and regional training institutes; publications including *Zero to Three* and *Clinical Infant Reports;* a fellowship program; public policy and public education activities; efforts to facilitate research and evaluation in the field; and work with state governments to plan comprehensive services for high risk infants and families. The National Center has reached out to those working with infants and their families in almost every conceivable setting or capacity. In ten years it has brought many thousands of dedicated service providers, researchers, educators, policymakers and parents together for meetings, provided regular educational material for additional thousands, offered training to 65 graduate fellows, published over 150,000 copies of special reports and touched the minds of policymakers at every level of government. It has collaborated with scores of philanthropic and advocacy organizations concerned with young children and families. NCCIP deeply values its dual mission—to promote best practice in work with infants, toddlers and their families and better understanding of why these activities are so important to individual families and to our society at large.

The Board of Directors of the National Center has declared 1987 as a year to celebrate the accomplishments of its first decade, to make its activities more broadly known, and to rededicate the organization to the greater fulfillment of its mission. Increasing awareness among the public at large of the importance of the infancy period as a foundation for later development has helped greatly in fulfilling these goals. We hope to expand this awareness and to use it as further fuel for action.

NCCIP anniversary activities will culminate in a gala celebration dinner here in Washington on December 3, 1987, the evening before the opening of the National Training Institute. This event will be hosted by Members of Congress, entertainers and other national figures who believe in giving America's children the right start. It will honor Irving Brooks Harris and Bernard Levy, two members of the Board whose personal commitment to the goals of the National Center have inspired their colleagues within and beyond the organization. A tenth anniversary publication will feature essays by leaders in the field reviewing the changing circumstances of infants, toddlers and their families; achievements in research, practice and policy; and challenges for the future.

We hope that many *Zero to Three* readers will come to Washington to celebrate a decade of working together to make a difference for babies and families, and to join forces for the tasks ahead.

Publications

Infants in Multirisk Families: Case Studies in Preventive Intervention (NCCIP Clinical Infant Report #3)—Stanley I. Greenspan, Serena Wieder, Alicia Lieberman, Robert Nover, Reginald Lourie and Mary Robinson, editors (Madison, Connecticut: International Universities Press, 1987) $40.00. **Use order coupon on p.27 to receive 20% discount.**

This 608-page volume, the third in the National Center for Clinical Infant Programs' Clinical Infant Reports Series, is based on the work of Stanley Greenspan and his colleagues with 47 multirisk families whose poor coping capacities threatened the development of their newborn infants. Beginning in 1977, the multidisciplinary staff of the Clinical Infant Development Program of the National Institute of Mental Health undertook, through intensive work with these families, to discover: 1) how psychopathology develops, in what patterns and configurations, in infants from multirisk families; 2) how the adaptive and maladaptive caregiving patterns in these families affect the infants' development; 3) what ideal combinations of clinical techniques and services delivery models would be needed to reverse maladaptive infant and caregiver patterns; and 4) which clinical techniques and service system approaches were effective for specific problems, on a case by case basis.

Four highly detailed case studies illustrate the program's imaginative diagnostic and preventive intervention approaches. Conceptual chapters identify the risk factors contributing to maladaptive functioning in mothers in the program; describe a model for comprehensive community services for infants and families; suggest an approach to developmental diagnosis; and offer a new formulation of the therapeutic process itself, as reflected in work with multirisk families.

continued on page 22

Call for POSTERS, VIDEOS and SYMPOSIA

National Center for Clinical Infant Programs

Fifth Biennial National Training Institute

"Frontiers and Front Lines: A Decade of Strengthening Infants, Toddlers and Their Families through Research and Practice"

Washington, D.C. December 4-6, 1987
J.W. Marriott Hotel

Institute themes

The National Center for Clinical Infant Programs is celebrating the tenth anniversary of its founding in 1977 with a training institute that will reflect NCCIP's multidisciplinary, multidimensional perspective on the earliest years of life.

This perspective emphasizes: 1) individual differences in infants and families, with a recognition, however, that all infants and families have many needs in common; 2) the interaction and intersection of multiple lines of development in the growing infant or toddler; and 3) the importance of relationships—between the baby and its partners, among family members, and between the family and its support system.

In an effort to offer participants in its institute opportunities to stretch their understanding beyond their own discipline or work experience, NCCIP will bring together the perspectives of professionals from many disciplines, of parents, of researchers and of policymakers. The training institute will look at both normative development and environments as well as at infants and families at risk, with the conviction that greater understanding of one area sheds light on many others. Plenary presentations will address the three areas listed above, as well as infant day care research and social policy issues.

Submissions from the field are invited for three types of presentations concerning research and practice on behalf of normal, disabled and at-risk infants, toddlers and their families.

Poster presentations

A Friday evening poster session/reception and a Sunday morning poster session/breakfast will provide presenters with opportunities to inform and converse with the more than 1000 anticipated institute participants. Posters may describe research findings, service delivery models, public education initiatives tools for assessment and evaluation, or approaches to parent and professional training.

Presenters will be provided tables on which to mount displays. Handouts are strongly encouraged. Presenters may arrange for slide or video table-top equipment at their own expense.

Videos

Both informational and clinical videos will be selected for presentation at several sessions during the 2-½ day institute.

A. Informational videos—These should be no more than 30 minutes in length and should be designed for trainee, parent or general audiences. They may deal with any aspect of child and family development during the first three years of life. Videos in this category should be available for loan, rental or purchase.

B. Clinical and research videos—These should be presentations of no more than 30 minutes in length of research or clinical material concerning infants, toddlers and their families. They should be designed for professional or trained audiences. Presenters will be expected to provide a framework for viewing these videos, to narrate as appropriate, and to answer questions from the audience.

Symposia

A total of approximately thirty 1-½ hour symposia will be offered at sessions on Friday afternoon, December 4 and at morning and afternoon sessions on Saturday, December 5.

Symposia should present more than a single perspective on a topic or idea concerning theory, research, practice or policy related to infants, toddlers and their families. Presenters may be from different disciplines within a setting, from different programs or institutions, or from different political jurisdictions.

Topics are not restricted. Of particular interest are presentations concerning collaboration among disciplines; effective approaches to underserved populations; research and practice addressing the infant's relationships with grandparents, siblings, extended family, foster parents and professional caregivers; and training for parents, professionals and paraprofessionals. Case presentations are encouraged; a discussant from outside the program *must* be included in proposals for case presentations.

Since only a fraction of the institute participants will be able to attend any one symposium, individuals who submit symposium proposals and who wish to reach a wider audience are encouraged as well to submit poster proposals that describe their research or practice. To facilitate the review process, these should be separate submissions.

Submission deadline and selection process

Abstracts and copies of videos must be received no later than *Wednesday, June 30, 1987.*

Submissions will be selected through a review process under the auspices of the NCCIP National Institute Planning Committee.

Persons selected to present will be notified by September 1, 1987.

Institute attendance

Symposium presenters are required to register at their expense for the entire training institute. Poster session and video presenters must pay full registration fees if they attend institute activities other than their own poster or video session. All presenters will be responsible for covering their own travel, per diem and materials costs.

Proposal format

- **Each** proposal should include a cover page which includes the following information:

1) Type of submission—poster, symposium, informational video or clinical/research video

2) Presenter/liaison—name, title, mailing address and daytime telephone number of *one* person to whom all institute correspondence can be addressed

3) Names, title addresses and business telephone numbers for *all* presenters involved in a symposium, case presentation or poster presentation

4) Audiovisual equipment needed for symposia. Poster presenters may arrange for table top slide or video equipment at their own expense.

- **Symposium proposals** should include six copies of a double-spaced narrative description of the proposed presentation no more than 3 pages in length. The narrative should present the idea or topic to be addressed, identify the perspectives that will be included, describe the research or service programs that form the basis for the presenters' expertise and highlight any areas of controversy. A 100-word description of the symposium that can be used in the institute program should also be encluded.

- **Case presentation proposals** should include six copies of a double-spaced description of the proposed presentation no more than 3 pages in length. Information should be included about the clinical issues addressed, the setting in which services were offered and the treatment approaches used. The proposal should also identify some of the issues likely to be raised by the discussant. A 100-word description of the presentation for use inn the Institute program should also be included.

- **Poster presention** proposals should include six copies of a 250-350 word double-spaced narrative description of the research, service, training, public education, or assessment/evaluation approaches to be presented. A 100-word description of the poster for use in the institute program should also be included.

- **Informational video** proposals should include a copy of the cassette (if possible, those selected for presentation will be retained until after the institute,) and a sample handout describing the purpose, designated audience and content of the video, along with ordering information.

- **Clinical video** proposals should include a copy of the cassette (if possible, those selected for presentation will be retained until after the institute) along with a one-page narrative description of the content of the video, highlighting the research or clinical issues it illustrates and the setting involved.

- **Two stamped envelopes** addressed to the presenter/liaison should be included with **each** submission. One will be used to acknowledge receipt of the proposal, the second to enclose notification of the Planning Committee's decision.

Selection criteria

1. Relevance to research, practice or public policy concerning normal, disabled and at-risk infants, toddlers and their families
2. Clarity and organization
3. Originality and innovativeness
4. Usefulness to practitioners
5. Adherence to guidelines

Send proposals (including cassettes) to:
Eileen Powell, Conference Coordinator
NCCIP
733 15th Street, N.W., Suite 912
Washington, D.C. 20005

For additional information about the National Training Institute, call Eileen Powell at (202) 347-0308.

Families in Peril: An Agenda for Social Change—Marian Wright Edelman (Cambridge, Massachusetts: Harvard University Press, 1987) $15.00.

Based on the 1986 W.E.B. Dubois Lectures which she delivered at Harvard University, Marian Wright Edelman, President of the Children's Defense Fund, documents the impact of poverty, adolescent pregnancy and misguided national priorities on American families, both white and black. She suggests a range of "preventive investment" strategies in health, nutrition and child care to address the immediate survival needs of poor children, as well as steps to bolster education and employment opportunities for heads of families. Edelman argues that "instead of worrying whether poor parents of infants on welfare are sufficiently motivated to work, we should move toward a system of universal availability of maternity and paternity leave and benefits, privately and publicly funded, establishing a consensus that we do not demand that a parent with an infant work, regardless of his or her economic status." Edelman also favors the flexibility of part-time jobs and reduction in the hours of full time work.

Describing the steps needed to bring about social change, Edelman points out that "a good children's issue...must not only be simple but winnable" and that effecting change is never a one-shot effort: even if desired legislation is passed, energies must be devoted to the "thankless but critically important tasks" of implementation, technical assistance and budget oversight.

Risk Factors in Infancy (Special Aspects of Education, Volume 7)—Alice Sterling Honig, editor (New York: Gordon and Breach Science Publishers, 1986) Hardcover, $55.00. Softcover, $18.00.

This collection of research and clinical papers investigates the many risk factors that singly or in combination can threaten the development of infants and young children. The reports examine the etiology and impact of such factors as prematurity, family poverty and inappropriate parenting and describe programmatic approaches to remediation. Alice Honig surveys risk factors in infancy; Craig Ramey and Jean Gowen present data from the longitudinal Carolina Abecedarian Project concerning modifying risk for retarded development; Leila Beckwith describes parent interaction with preterm infants and later mental development, as observed in the longitudinal prospective study of the UCLA Infant Studies Project; David Olds examines factors interfering with nurse home visitors' effectiveness with high-risk families; and Stanley Greenspan, Robert Nover and Alfred Scheuer present their developmental diagnostic approach for infants, young children and their families. Additional contributors include Mercedes de Cubas, Tiffany Field, Sarah Friedman, Blanche Jacobs, Milton Wirthman and Frank Oski.

Sexual Abuse of Young Children: Evaluation and Treatment—Kee MacFarlane and Jill Waterman with Shawn Conerly, Linda Damon, Michael Durfee and Suzanne Long (New York: The Guilford Press, 1986) $27.95.

This volume grew from the efforts of five colleagues in the Preschool Age Molested Children's Professional Group in Los Angeles to put in writing what they had learned in their collective years of working with very young victims of sexual abuse. The multidisciplinary group of authors address evaluation, treatment and the broader context of social and legal issues. Chapters on evaluation include attention to the child's developmental level in interviewing, tools for psychological evaluation, and guidelines for sensitivity in physical examinations. It is noteworthy that the review of existing treatment literature in the shortest chapter in the book. In discussing treatment, the authors of the present work describe an individual modified play therapy treatment for young children, address issues of case management and teaming, and suggest ways to help parents cope with extrafamilial molestation.

Special Children—Special Risks: The Maltreatment of Children with Disabilities—James Garbarino, Patrick E. Brookhauser and Karen J. Authier (Hawthorne, NY: Aldine de Gruyter, 1987). Hardcover, $39.95. Softcover, $19.95.

Handicapped children and youth do, the authors of this volume argue, experience special risk for maltreatment. Many handicaps observed in children may be the *result* of earlier maltreatment. Social context is important, however: in some families, the presence of a handicapped child may elicit unusually strong and positive interaction, and in some communities special resources may be available to support families with handicapped children, thus reducing risks of abuse.

Five chapters in this volume deal with the identification of special risks for handicapped children and five with intervention to protect these children. The chapter by Car/Dunst and his colleagues on "Supporting Families of Handicapped Children" suggests that help and assistance from members of their social support networks can promote family adaptation to a handicapped child and lessen or alleviate negative consequences and reactions. A "proactive" approach, focused on strengthening families, is advocated to replace a deficit-oriented treatment model.

Risk in Intellectual and Psychosocial Development—Dale C. Farran and James D. McKinney, editors (Orlando, Florida: Academic Press, Inc., 1986). Hardcover, $48.50. Softcover, $24.95.

The authors of this volume note that in this country we may have begun service programs to prevent problems in development in children without adequate information as to: 1) Can we be reasonably certain about risk indicators? and 2) If we are certain, do we have data to support any particular intervention to forestall the consequences of the risk?

Chapters in this book provide data from longitudinal projects concerned with risk in intellectual development and in psychosocial development. Authors of these chapters include Emmy Werner, Ron Haskins, Craig Ramey, John Ogbu, James McKinney, Stanley Greenspan, Richard Bell, Dale Farran and Lee Robins. In a chapter on "Prevention Services for Risk Children: Evidence for Policy and Practice," Barbara Koegh and her colleagues conclude from their review of empircal data that "the link between prevention and risk condition is supported on many levels and from different professional and disciplinary perspectives." They suggest that ambiguity of definition of "health" and "risk;" professional and technical limitations in screening and assessment; confounding of social, political and economic considerations; and limited advocacy for at-risk children have led to selective and often fragmented preventive services for infants, children and youth.

Children with Spina Bifida: Early Intervention and Preschool Programming—G. Gordon Williamson, editor; Margery Szczepanski, assistant editor (Baltimore, Maryland: Paul H. Brookes Publishing Company, 1986) $23.95.

Designed for professionals working with young children with spina bifida, this book attempts to report the knowledge and skills required by the practitioner, reflecting exemplary professional practices based on current research in the field. Authors represent the major rehabilitative, educational and psychosocial disciplines. They stress close collaboration with parents in designing a personalized service plan that enhances the developmental competence of the individual child and the coping resources of the family.

Chapters describe procedures for interdisciplinary assessment and intervention in the following areas: postural control and mobility, perceptual-motor skills, speech and language, activities of daily living, and unique educational requirements. Methods, materials and intervention strategies are discussed for each content area.

Guidelines for Assessing Parenting Capabilities in Child Abuse and Neglect Cases— Children's Charter of the Courts of Michigan, Inc. and Michigan Association for Infant Mental Health (Lansing, Michigan: Michigan Department of Mental Health, 1986) available for $5 from MAIMH, c/o Department of Psychology, Michigan State University, East Lansing, Michigan 48824-1117.

These guidelines for assessing parenting capabilities in child abuse and neglect cases, with special reference to infants of mentally ill and mentally impaired parents, were developed by a joint committee appointed by the Children's Charter of the Courts of Michigan, Inc. and the Michigan Association for Infant Mental Health. They represent a collaboration between probate judges and attorneys and mental health practitioners. The 28-page booklet reviews the juvenile court process and infant mental health principles, including parental needs after removal of an infant. The content and conditions of an assessment of mentally ill or mentally impaired are described, and questions presented that may be used to arrive at a determination of risk. The Committee suggests criteria for recommending termination of parental rights and makes related recommendations for intervention and support services to help parents with limited capabilities raise their children successfully.

Language Development from Birth to Three—Moshe Anisfeld (Hillsdale, NJ: Lawrence Erlbaum Associates, 1984) $16.50.

This book delineates the normal course of language development, which the author sees as part and parcel of cognitive and social development in general. Reflecting this view, the book includes two chapters on the development of the symbolic capacity in infancy which synthesize Piagetian theory of sensorimotor development with recent empirical research. The symbolic capacity is seen as a prerequisite for the differentiation of the self, genuine communication, and language.

The material is organized into three parts. The first part begins with a description of the nature of symbols and their development in the first year and ends with an analysis of the development of word meanings in the second and third years. The second part moves from the word level to the sentence level. In addition to reviewing what is known about the characteristics of the children's early sentences, the second part clarifies the different theoretical views of the development of syntax. The third part deals with the acquisition of phonology and morphology, approaching these more technical aspects of language from a psychological perspective.

With regard to the role of parents in children's acquisition of language Anisfeld makes the point that no one method of linguistic guidance is indispensable. According to Anisfeld, what is important for promoting good language growth in the initial stages is that the caregiver speak to the child on matters the child is focusing his/her interest upon at the moment. The caregiver should not introduce new information, but make her utterances redundant with the information the child is deriving from the nonverbal context on which he/she is focused. In this way the child will be able to figure out the meanings of the utterance which he/she hears.

Conference Call

April, 1987

April 29-May 2: *Miami Children's Hospital Division of Pulmonology* and *SKIP of Florida* will present a conference on "The Technology Dependent Child and Family: Alternatives for Care" in Coral Gables, Florida. Speakers will include Hon. Lawton Chiles, Edward Lis, Steven Freedman, Karen Shannon, Karen Buckholtz, Robert Kettrick, Mary Donar, Phyllis Magrab, Parnall Searl, Aaron Favors, Naomi Karp, and Kathleen Kirk Bishop, among others. Write or call the Division of Pulmonology, Miami Children's Hospital, 6125 S.W. 31st Street, Miami, Florida 33155, tel: (305) 662-8383.

May, 1987

May 11-13: *The Department of Rehabilitation Medicine, The New York Hospital* and *Contemporary Forums* will sponsor a conference on "Issues in Infant Development" in New York City. Conference faculty will include Delia Gorga, Michael Lewis, Klaus Minde, Arnold Sameroff, Linda Siegel, Anita Sostek, Francine Stern, G. Gordon Williamson and Peter Wolff. For information, write or call Contemporary Forums, 530 LaGonda Way, Suite E, Danville, California 94526, tel: (415) 820-2800.

May 15-16: *The Family Child Learning Center, Children's Hospital Medical Center of Akron* and *Kent State University Colleges of Education and Speech Pathology and Audiology* will sponsor a conference entitled "Infant Intervention: Roles of Families and Professionals" in Akron, Ohio. The faculty includes Paula Beckman, Philippa Campbell, Arnold Capute, Carl Dunst, Joseph Fagan, Rebecca Fewell, Delia Gorga, Marci Hanson, Jack Shonkoff, Lisbeth Vincent and G. Gordon Williamson. Contact Joan Markouski, Family Child Learning Center, 1909 Third Street, Aujahoga Falls, OH 44221, tel: (216) 923-4535.

May 18-22: *The C. Henry Kempe National Center for the Prevention and Treatment of Child Abuse and Neglect, University of Colorado Health Sciences Center,* will sponsor its sixteenth annual Child Abuse Symposium, a review of 25 years of child abuse and neglect legislation, programs, research and clinical practice, in Keystone, Colorado. Faculty will include Jane Burnley, Howard Davidson, Janet Dean, Vincent de Francis, Kee MacFarlane, Clare Haynes-Seman, Ruth Kempe, and Robert ten Bensel. Contact the C. Henry Kempe National Center, 1205 Oneida Street, Denver, Colorado 80220, tel: (303) 321-3963.

May 18-20: *The Early Childhood Research Institute* at *Utah State University,* the *University of North Carolina,* the *University of Pittsburgh* and the *U.S. Office of Special Education Programs* will sponsor a conference in Arlington, Virginia entitled "Focusing on the Future: Linking Research, Policy and Practice in Early Intervention." Senator Lowell P. Weicker will deliver the keynote address. The accomplishments of the early research institutes will be described in plenary sessions. For information contact Mary Ellen Heiner, UMC 6850, Utah State University, Logan, Utah 84322-9981, tel: (801) 750-1172.

May 21-22: *The Department of Economic Security, Division of Developmental Disabilities, District V in Arizona* will sponsor its second annual Prevention/Intervention Networking Conference in Coolidge, Arizona. Presenters will include members of several professional disciplines and parents of special needs children. Contact Julene Hollenback, Family and Child Services, Division of Developmental Disabilities, P.O. Box 1457, Coolidge, Arizona 85228, tel: (602) 723-4151

May 24-27: *The Association for the Care of Children's Health* will sponsor its 22nd annual conference in Halifax, Nova Scotia. Sessions will address topics including parent-professional relations, cultural issues in health care, interventions with siblings, and home care for infants with special health needs. Write ACCH, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016-3007.

May 27-30: *The National Association of Perinatal Social Workers* and *Huntington Memorial Hospital* will sponsor the association's eleventh annual conference in Los Angeles, California. Contact Chairperson Rita Melvin, Huntington Memorial Hospital, 100 Congress Street, Pasadena, California 91109, tel: (818) 440-5202.

June, 1987

June 1-2: *The Infant-Parent Institute* will sponsor a symposium entitled "Birth of a Sick or Handicapped Baby: How Families Cope" on the campus of the University of Illinois at Urbana-Champaign. Presenters will include Judith Atzkowitz, Eva Thorp, Jeanette McCollum, Kathleen Moroz and Michael Trout, as well as parents and siblings of children with disabilities. Write or call Michael Trout, The Infant-Parent Institute, 501 South Sixth, Champaign, IL 61820, tel: (217) 352-4060.

June 11-12: *Resources for Child Care Management* will sponsor a conference on "Child Care at the Workplace" in Chicago, Illinois. Presenters will include Bettye Caldwell, Dana Friedman, Ellen Galinsky, Robert Lurie, Gwen Morgan, Fran Rodgers and Marelene Weinstein. Contact RCCM, P.O. Box 672, Bernardsville, NJ 07924, tel: (201) 766-9237.

June 12-13: *The Parent Services Project, Dominican College* and the *Family Resources Coalition* will co-sponsor a conference in San Rafael, California entitled "Life Cycle of the Family: Challenges for Research, Community Services and Public Policy." Ellen Galinsky will be the keynote speaker. Call (415) 454-1811 for more information.

June 22-26: *Erikson Institute* will sponsor an advanced training course in child abuse prevention at Loyola University, Chicago, Illinois. The course will be taught by James Garbarino, with guest lecturers Anne Cohn, Jon Conte and Judith Musick. Write or call the Registrar, Erikson Institute, 25 West Chicago Avenue, Chicago, Illinois 60610, tel: (312) 280-7302.

June 22-26: *The Frank Porter Graham Child Development Center* will present an intensive summer institute at the University of North Carolina, Chapel Hill on "Programs for Infants, Toddlers and Their Families." Sandra Scarr, Susan Aronson, Sharon Landesman and James Gallagher will be keynote speakers. Faculty for in-depth study areas will be Donald Bailey, Richard Clifford and Thelma Harms. Contact Nancy Stiniste, FPG Summer Institute, 300 NCNB Plaza, Chapel Hill, NC 27514, tel: (919) 962-7360.

July, 1987

July 17-23: *The North Dakota Occupational Therapy Association* will sponsor a two-part workshop on "Assessment and Treatment of Developmental Dysfunction" in Fargo, North Dakota that will include hands-on experience with children. Part I (July 17-19) will address hand problems and Part II will address vision problems. Contact Erhardt Workshop, North Dakota Occupational Therapy Association, P.O. Box 8035, Fargo, North Dakota, 58109-8035, tel: (701) 237-6456.

July 25: *The World Association for Infant Psychiatry and Allied Disciplines (WAIPAD)* and the *International Psychoanalytic Association* will sponsor a meeting on "Clinical Topics in Infant Psychiatry" in Montreal, Canada. Presenters and discussants will include Klaus Minde, Jean-Francois Saucier, James Anthony, Bertrand Cramer, Daniel Stern, Serge Lebovici, Yvon Gauthier, Joy Osofsky and Robert Emde. Write to Yvon Gauthier, M.D., Universite de Montreal, Faculte de Medecine, C.P. 6128, succursale A, Montreal (Quebec) H3C 3J7, Canada.

August, 1987

August 24-27: *The Infant-Parent Institute* will present its seventh annual Brief Summer Course in Infant Mental Health on the campus of the University of Illinois at Urbana-Champaign. Principal instructor will be Michael Trout, Director of the Institute. Contact Mr. Trout at the Infant-Parent Institute, 501 South Sixth, Champaign, IL 61820, tel: (217) 352-4060.

September, 1987

September 10-12: *The University of Wisconsin* will present a conference in Madison, Wisconsin on "Child Advocacy as a New Role for Professionals." Parental, individual and class advocacy issues will be addressed in areas including special education needs, child abuse and neglect and divorce. Write to Ann Bailey, Continuing Education Coordinator, University of Wisconsin, 610 Walnut Street, Room 136, Madison, Wisconsin 53705.

November, 1987

November 1-3: *The Division for Early Childhood (DEC) of the Council for Exceptional Children* will hold its third annual national conference on Young Children with Special Needs and Their Families in Denver, Colorado. Contact Early Childhood Conference, c/o Early Childhood Research Institute, 3811 O'Hara Street, Pittsburgh, Pennsylvania 15213, tel: (412) 431-3371.

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Ongoing Training Opportunities

Wheelock College Graduate School has received a personnel preparation grant from the Office of Special Education and Rehabilitative Services, U.S. Department of Education which will enable masters' level students in early intervention to focus on families. A family specialist will supervise student work with families in practicum settings; and a parent of a child with special needs will co-teach and consult in several courses.

The Wheelock College Graduate School has offered a personnel program since 1980 to train students for roles such as infant developmentalists, parent educator, team collaborator, facilitator of the parent-child relationship and program developer and advocate. For information about admission and full or part-time students contact Susan McBride, Wheelock College Graduate School, 200 The Riverway, Boston, MA 02215, tel: (617) 734-5200 x 199.

Women and Infants' Hospital and *Bradley Hospital* in Providence, Rhode Island are recruiting trainees for an NIH funded 9-month program in psychosocial preventive intervention with high-risk infants and their families. The program includes didactic seminars, clinical demonstrations and practica, and individual supervision. It will run from September, 1987 to June, 1988. Faculty include Barry Lester (Program Director), Tom Anders, Ellie Berez, Zack Boukydis, T. Berry Brazelton, Cynthia Garcia Coll, Peter Gorski, Kevin Nugent, Barry Nurcombe, William Oh, Arnold Sameroff, Carol Seplecki, Mary Sheagh, Edward Tronick, Betty Vohr and Charles Zeanah. For more information contact Elaine Mayer, Program Coordinator, at Bradley Hospital, tel: (401) 434-3400 x 324.

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Register now for NCCIP's Fifth National Training Institute, December 4-6, 1987 Washington, D.C. See pp. 19-22

The Application of a Transactional Risk Model to Intervention with Multi-risk Maltreating Families

by
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Associate Professor of Psychology and Psychiatry
University of Rochester
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Sheree L. Toth, Ph.D.
Assistant Professor
Department of Psychology
University of Rochester
Mt. Hope Family Center

At Mt. Hope Family Center of the University of Rochester we have been striving to integrate a theoretical model developed to address the occurence of child maltreatment with the development of a model of intervention for these high risk families. Involvement in a center specializing in developmental psychopathology, a discipline which stresses the importance of understanding the relationships among normal and pathological development, provides a forum for us to combine our research perspective with an actual service delivery system. This is especially important, since our goal as clinical-developmental psychologists has been to work toward the formulation of a theory of development that attends to the relationships among cognitive, linguistic, socio-emotional, and biological domains and the application of resulting research to intervention programs. In efforts to accomplish this, we have focused on both clinical and normal populations of children. Even when we both worked solely in academic departments in a university setting, we hoped that our work would lead to improvements in the treatment of, and intervention on the behalf of, disadvantaged children and their families. Since we adopted this goal, we have always tried to span the dualisms that too frequently exist today between clinical intervention with and research into childhood disorders, between basic and applied research, and between developmental psychology and psychopathology. In this paper, we will present the application of a theoretical model derived from research to intervention with multi-risk maltreating families. Before describing the model,

Robert Maust

We would like to thank the clinical, educational, and administrative staff of Mt. Hope Family Center for their commitment and dedication to the families which we serve and for their support of the Center's integrative approach toward research and service provision. Our appreciation also is extended to Victoria Gill for typing this manuscript. Finally, the writing of this paper was supported in part by a grant from the National Institute of Mental Health (R01-MH37960) to Dante Cicchetti.

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however, we offer an historical framework that may be helpful in understanding the delay in the integration of these perspectives.

Factors contributing to the research/clinical dichotomy

Unfortunately, a number of factors have historically contributed to the communication split between those conducting research and the clinical application of research findings (Cicchetti, 1984; Santostefano, 1978). Prior to the late 1970's it was quite common for clinicians, whose primary interest was helping patients and bettering the plight of those suffering from a medical condition, to adopt a "medical model" of psychopathology, thereby modeling physicians who treated organic disorders. Conversely, academic psychology, due to its development in a university rather than a clinical setting, failed to recognize the utility of the medical model. If clinical psychologists and psychiatrists emulated the physician, academic psychologists emulated the physicist. Concerned with conforming to the strict canons of the scientific method, academic psychologists generally emphasized quantification to the exclusion of more subtle clinical phenomenon. This attitude translated into academicians believing that any research that was not basic research was not sufficiently scientific and rigorous. Clinicians, on the other hand, tended to underestimate the importance of academic research, not only for advancing psychology, but also for solving everyday clinical problems.

Fortunately, in recent years a confluence of factors has lessened the separation of disciplines described above so as to allow for the combining of the skills of the academic psychologist and the clinician in the person of the developmental psychopathologist. We believe that the use of research in normal developmental processes, in combination with work with emotionally disturbed children, can be integrated to guide a theory of intervention with dysfunctional families.

A transactional "risk" model of child maltreatment

Intervention with multi-risk families has proven to be especially challenging for clinicians and researchers alike. Service providers frequently fail in their efforts to help these families deal with the chaos of their lives due to the extreme nature and number of stressors with which the families are confronted. Concomitantly, researchers try to combat the distrust, mobility, and high attrition rate of these families while conducting longitudinal studies of development and intervention outcome. These families are the most difficult to engage due to the multiple risk factors with which they are faced. Poverty, intellectual and educational limitations, social isolation, and psychiatric disturbances are but a few of the variables comprising the "multi-risk" equation.

A concept especially relevant to multi-risk families and maltreatment involves "risk factors" (Cicchetti & Rizley, 1981). Cicchetti and Rizley define risk factors as belonging to two broad-based categories: 1) **potentiating** factors which increase the probability of the occurence of maltreatment and 2) **compensatory** factors, which decrease the risk of maltreatment. In addition, two subgroupings are subsumed under each category. These include transient fluctuating, "state" factors and more permanent, enduring "trait" factors.

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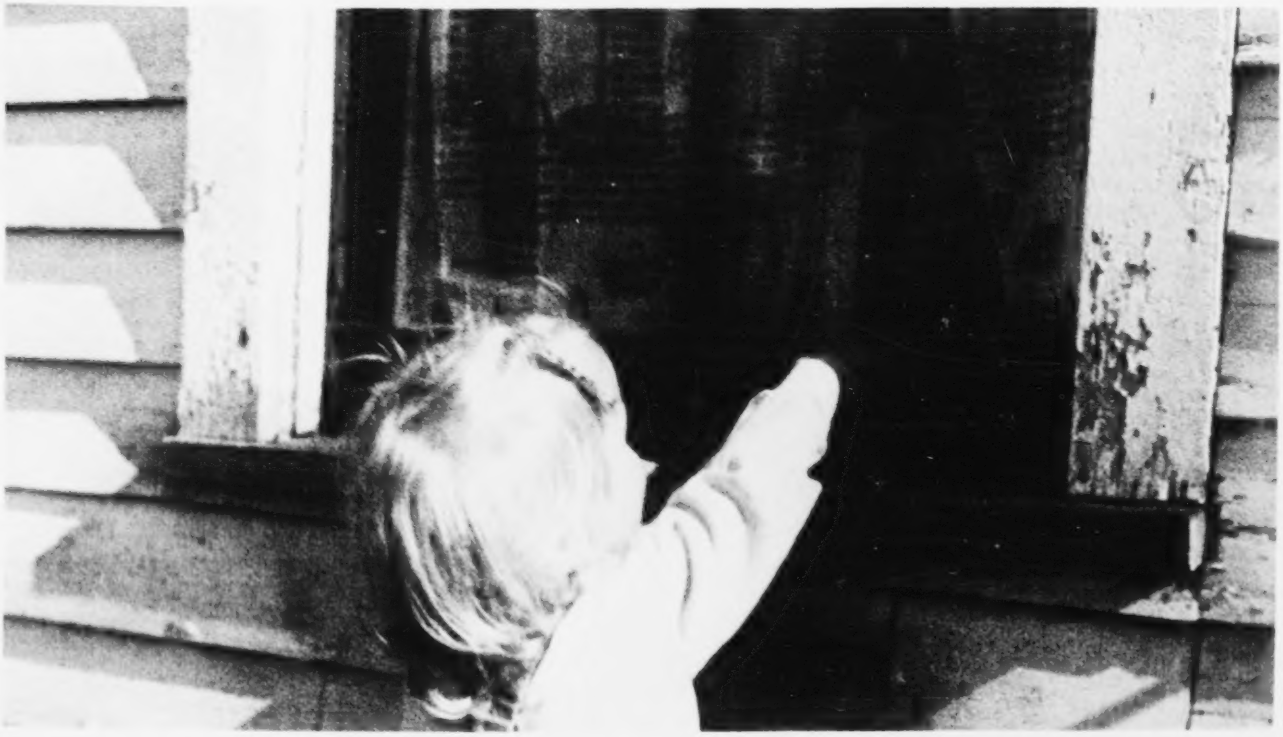

Barbara Young

Long-term vulnerability factors include all relatively enduring factors, conditions or attributes that serve to potentiate maltreatment. These may involve parental, child, or environmental characteristics. Vulnerability factors may be biological in nature (e.g., a child with difficult temperament, physical or behavioral anomalies that make child-rearing unrewarding or difficult, etc.); historical (e.g., a parent with a history of being maltreated); psychological (e.g., personality characteristics such as poor frustration tolerance, psychopathology on the part of parent or child, or high trait levels of aggression and anger); and sociological (e.g., high stress levels, inadequate social networks or chaotic neighborhoods).

Transient challengers include the short-term conditions and stresses that confront families which may cause a predisposed parent to maltreat his or her child. Significant stressors include: loss (of status, a job, or a loved one); physical injury or illness; legal difficulties; marital or family problems; discipline problems with children; and the emergence of a child into a new and more difficult developmental period.

Long-term protective factors include those relatively enduring or permanent conditions or attributes that decrease the risk of maltreatment or its transmission across generations. Examples of protective factors include "desirable" attributes in parents and children, such as; good temperament, high intelligence, flexibility and adaptability, enduring good health, a parent's history of good parenting, good education, and secure intimate relationships between parental figures.

Transient buffers include factors that may protect a family from stress, thereby reducing the probability of maltreatment and its transmission. Probable buffers include: sudden improvement in financial conditions, parent's finding desired work, child's entry into school or daycare, periods of marital harmony, and a child's transition out of a difficult developmental period.

According to Cicchetti and Rizley (1981), maltreatment is expressed only when potentiating factors override compensatory ones. It is then that an act of maltreatment is committed or a maltreatment condition is allowed to begin. It has been well documented that maltreating families possess a large number of the potentiating risk factors described by Cicchetti and Rizley (1981). The seminal work of Egeland (Egeland, Breitenbucher, & Rosenberg, 1980), Garbarino (Garbarino & Gilliam, 1980), and Pelton (1978) dramatically underscores the vast array of long-term vulnerability factors and short-term challengers experienced by maltreating families. In order for intervention to be successful with such multi-risk families, it is critical that a broad-based treatment approach be employed (see, for example, the recommendations of Cicchetti, Taraldson, & Egeland, 1978). Treaters must possess a flexible array of skills, and intervention must occur at all levels of the transactional process—parent, child, and environment. The goal of this intervention is to increase protective factors and buffers, while reducing vulnerability factors and challengers.

In addition to assessing the presence of risk factors in maltreating families, developmental psychopathologists are beginning to assess the consequence of child maltreatment on the developmental process. A major area of research relates to the impact of maltreatment on the negotiation of stage-salient tasks of infancy and toddlerhood.

Stage-salient developmental issues in maltreated youngsters

In recent years, a consensus has emerged regarding the importance of stage-salient tasks within the developmental process (Erikson, 1950; Greenspan, 1981; Sroufe, 1979). Rather than construing development as a series of unfolding tasks that need to be accomplished but then decrease in importance, we see development as consisting of a number of important age and stage-appropriate tasks that, upon emergence, remain critical to the child's continued adaptation. Although these issues decrease in their importance with respect to other newly emerging tasks, each issue represents a task that requires ongoing coordination and integration in the individual's adaptation to the environment throughout the life span. Furthermore, there are corresponding roles for caregivers that increase the probability that their children will successfully resolve each stage-salient issue (see Sroufe, 1979).

Research on how maltreated youngsters negotiate stage-salient developmental issues has just begun to capture the attention of developmentalists. Specifically, two stage-salient issues of the early years of life have been assessed in maltreated children: 1) the development of a secure attachment relationship with the caregiver; and 2) the development of an autonomous self.

The development of attachment relationships

The development of a secure attachment relationship with the primary caregiver is considered to be the central stage-salient developmental issue between the age of six and twelve months (Sroufe, 1979; Sroufe & Rutter, 1984). It is marked by increased attention and attunement to interpersonal interactions (Stern, 1985). Although the capacity for attachment originates in earlier stages, this issue reaches ascendancy in the latter half of the first year of life (Sroufe, 1979). Dyadic interactions, marked by relatedness and synchrony, resiliency to stress, and appropriate affective interchange, are associated with successful adaptation during this stage (Sroufe, 1979). Insensitivity from the caregiver is likely to exert a negative impact on the infant's ability to master this stage. In the absence of regular contingent responsivity, neither infant nor caregiver develops feelings of efficacy, and the development of a secure attachment relationship may be hindered (Ainsworth, Blehar, Waters, & Wall, 1978).

Several investigators have documented that maltreated infants and toddlers are significantly more likely to form insecure attachment relationships with their primary caregivers than are youngsters drawn from well-matched, lower-SES comparison groups (Crittenden, in press; Egeland & Sroufe, 1981; Schneider-Rosen, Braunwald, Carlson, & Chicchetti, 1985).

The development of an autonomous self

The toddler's emerging development of an autonomous sense of self, seen as encompassing both emotional and intellectual dimensions, is a significant developmental task during the second and third years of life (Lewis & Brooks-Gunn, 1979; Stern, 1985). The evolution of this ability enables the toddler to understand environmental occurences more fully. A well-developed sense of self also provides the toddler with a greater comprehension of functioning as a separate and independent person. Caretaker sensitivity and ability to tolerate the toddler's strivings for autonomy, as well as the capacity to set age-appropriate limits, are integral to the successful resolution of this issue.

Research on the presence of visual self-recognition in maltreated toddlers has shown that the affective responses of these toddlers are strikingly different from those of a matched group of non-maltreated toddlers (Cicchetti & Schneider-Rosen, 1984). Specifically, while most children from the middle-and lower-social classes exhibit positive affective responses when they see themselves in the mirror with a lot of rouge on their nose, the majority of maltreated youngsters show neutral or negative affect. These results suggest that maltreated toddlers either attempt to mask their feelings or experience themselves in mainly negative ways.

Between 24 and 30 months, toddlers develop the ability to construct even more advanced mental representations of their environment. Investigations of the "self system" in maltreated children have been conducted by researchers interested in emotional language (e.g., talking about feelings). Maltreated toddlers talk less about their feelings or about the feelings of others than a matched group of non-maltreated children (Cicchetti & Beeghly, 1987). Moreover, the maltreated children's emotional language focuses on the "here and now" and not on absent persons or objects.

These "self system" difficulties bode poorly for future adaptation. Bemporad, Smith, Hanson, and Cicchetti (1982) have documented a high incidence of early maltreatment in children with borderline syndromes, viewed by many as a disorder of the "self system." Moreover, the concurrent relationship between childhood maltreatment and depression, another disorder that is affected by and affects the self system, has been described by Kazdin, Moser, Colbus, and Bell (1985). Accordingly, it is imperative that work with parents, homemakers, and day-care teachers focus on helping these children to develop a positive sense of self. If intervention occurs during these early phases, severe future dysfunction may be prevented.

The tendency for maltreated toddlers to use fewer emotional words may stem from parental disapproval of the expression of affect or of a certain class of affects. In effect, these children may become "over-controlled" in efforts to meet parental demands. Since a maltreating parent may have difficulty tolerating affective expression, alternate caregivers may be necessary. However, the fact that this over-controlled stance is likely to serve as an adaptive coping strategy for the maltreated child must not be disregarded (cf. Schneider-Rosen et al., 1985). Altering the toddler's mode of interacting without assuring the environment's ability to tolerate this change would be a disservice. Therefore, intensive work with the parent must precede a more child-focused intervention.

A model for intervention

Overall, research on the disturbances evidenced in the attachment relationship and self systems of maltreated youngsters reinforces clinical connections about the need for comprehensive systems of intervention that address multiple risk factors, including parent/child/environment, as well as multiple lines of development. The extent and magnitude of problems experienced by these multi-risk families and their impact on the development of young children cannot be adequately addressed through interventions designed to impact on only one component of the complex problem network. While some benefit can be derived from provision for concrete survival needs such as food and shelter, this in and of itself is only one area requiring intervention. Once the survival needs, or buffering factors have been put in place, interventions designed to impact on the family vulnerability factors also are required.

One way of conceptualizing a model of intervention which recognizes the need for attending to all components of a dysfunctional family system is through the application of a transactional model. According to this model, the multiple transactions among parental, child, and environmental characteristics all affect child development in an ongoing manner (Sameroff & Chandler, 1975). Accordingly, pathological child development presumes that a child has been involved in a continuous maladaptive process involving parental and environmental factors, as well as child-specific elements. Since the parent/child/environment system is seen as exerting reciprocal influence among all components, child development builds not only on the quality of earlier adaptation, but also on intervening environmental responses. It is therefore difficult, if not impossible, to isolate the relative impact of any single variable on a child's overall adaptation. Moreover, attempts to intervene in a maladaptive process by intervening in one component of dysfunction in a multi-risk family are likely to result in frustration for the intervenor, as well as in failure of the intervention.

Mt. Hope Family Center

Mt. Hope Family Center of the University of Rochester was established in 1979 as a center for the prevention of child maltreatment. Since its inception, the center has evolved into a facility for preventive interventions with children considered to be at high risk for the development of future emotional disturbances (e.g., children with a depressed parent, disadvantaged children, etc.). Integration of a research component into this setting has been of paramount importance, since it is our belief that utilization of a research paradigm can help us to develop more theoretically sound interventions. A multi-disciplinary approach which employs the expertise of social workers, special educators, speech therapists, psychologists, and psychiatrists is utilized. A home-based component is available for families unable to attend the Center, and a therapeutic preschool is provided for all children. Therapeutic services in the form of group and individual therapies also are offered to children and parents. Efforts to address the concrete needs of these families through the provision of transportation, baby sitting, and facilities of liaison with agencies providing food, clothing, and shelter also are integral to the program's success. Many of the families receiving services at Mt. Hope Family Center have been indicated in cases of child maltreatment, and the goal of the program is to intervene in order to reduce the magnitude of family risk factors, while increasing protective factors and buffers. The application of the transactional risk model previously described is considered to be central to successful intervention with multi-risk maltreating families.

Barbara Young

Mt. Hope Family Center is a mandated center for treatment of child abuse and neglect and as such receives funding for families considered to be at risk for maltreatment through the Monroe County Department of Social Services. The New York State Department of Special Education also provides funding for children requiring special services due to the presence of a handicapping condition. Support from other private and federal foundations has been received, and efforts to obtain additional monies to provide for the expansion of services which we envision are continuing.

While we will focus on the early years of life for the purposes of this paper, Mt. Hope Family Center's philosophy of treatment is to offer services to families throughout the lifespan. This "Life Center" approach flows logically from the risk model previously described and can, in a sense, serve as a long-term protective mechanism for those families. For example, a family may become involved with Mt. Hope following the birth of their first child, who subsequently receives therapeutic day services. Once trust is established, it is important that parents continue to feel connected enough to return to Mt. Hope even after the initially identified child is no longer in need of day services. When future stressors, such as the birth of another child or behavioral problems with older children occur, the ongoing availability of a consistent and supportive agency can compensate for the hopelessness and despair which these families might otherwise feel. As the ebb and flow of stressors within the life cycle of the family occurs, an intergenerational thread of services provided by Mt. Hope may become woven into the family system. In fact, our experience has shown that families are able to establish trust in the Center and often seek continued involvement during periods of stress.

In the following vignette, we have chosen to describe the background of a representative multi-risk family served at Mt. Hope Family Center. This will provide a sense of the clinical challenges and the need for the provision of a comprehensive range of intensive services which may well need to address lifespan issues if intervention is to succeed. In addition, the use of a transactional risk model of intervention will be described.

The S family

The case of the S family illustrates the extent of problems and extreme neediness of the multi-risk families served by the center. Mrs. S and her three-year old son Cal were referred to the Center following the arrest of Mr. S for the sexual abuse of his teen-aged daughter, Susan. Prior to his incarceration, Mr. S had physically and emotionally abused Mrs. S, as well as their five children (aged 3-16). At the time of referral, Mrs. S, aged 33, presented as willing to cooperate with treatment, but overwhelmed by a multitude of stressors. Her first pregnancy had occurred at the age of sixteen, and she had been victimized by her husband for an equivalent number of years. Since Mr. S had become sexually involved with Susan, Mrs. S had been relegated to the role of housekeeper.

Although the details of her history were slow to emerge, Mrs. S did share that she had been physically abused by her step-father prior to her marriage. This pattern of abusive relationships and the lack of any consistently supportive individuals in her life had resulted in a sense of extreme isolation and helplessness in Mrs. S. While she recognized the need for involvement at Mt. Hope, her historical pattern of passivity, coupled with her borderline mentally retarded intellectual functioning, severely limited her capacity to attend counselling sessions. The birth of a child to the S's sixteen-year old daughter, resulting from her sexual relationship with her father, coupled with the arrest of the family's teen-aged sons on charges of shoplifting and vandalism, exacerbated the intensity of environmental stressors.

Not surprisingly, at the time of referral the functioning of three-year-old Cal also was severely compromised. Cal evidenced deficits in language as well as in interpersonal skills, and it was not possible to obtain a cognitive assessment. However, the examiner concluded that Cal had pervasive cognitive and emotional deficits. Initially, Cal was unable to engage with either adults or peers and frequently gazed off into space with a blank expression on his face despite staff efforts to help him engage with his environment. Self-stimulating and stereotypic behaviors also were present.

This history immediately calls to attention factors which are likely to increase the potential of future maltreatment occurring within this family system. Mrs. S's previous history of maltreatment by her step-father, her limited intelligence, and her depression served as long-term parental vulnerability factors. Child-specific vulnerability factors included Cal's cognitive and language deficits. The family's poverty and absence of social support network were environmental factors which further potentiated the risk of maltreatment. These risk factors were compounded by the more acute stressors of the birth of the child to Susan and Mrs. S's sons' involvement with the legal system.

In applying the transactional risk model to intervention with this family, several areas of focus can be identified. Unfortunately, long-term protective factors were not present in this family. Therefore, treatment efforts needed to focus on the facilitation of the development of buffering factors. This was done by decreasing the intensity of stress by securing support services to meet the needs of the children. Cal was enrolled in the Mt. Hope preschool, which he attended five days per week. Mrs. S was helped to negotiate the legal system with her sons, who were subsequently placed in a juvenile detention facility. While this was difficult for Mrs. S, she was helped to recognize that the behavior of her sons was so difficult to manage that no other option was feasible. Cal's five-year-old brother also was evidencing severe emotional difficulties, and a day treatment placement was located for him. Intervention also was directed toward helping Mrs. S to secure financial assistance and to plan how to manage the money received so as to provide food, clothing, and shelter for her family. This was a slow process, and on many occasions the therapist found insufficient food in the home during her visits.

Once the therapist felt that adequate attention had been directed toward the development of buffers, the task of trying to impact on the family's vulnerability factors became more central to intervention. This was addressed through Mrs. S's involvement in weekly counselling sessions which sometimes included Susan, and provision of speech therapy and play therapy to Cal in conjunction with his preschool experience. Mrs. S was slow to trust her therapist, but the persistent process of outreach in combination with provision of

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concrete assistance helped her to engage with her therapist. She was able to develop a regular schedule of therapeutic contacts and began to feel a greater sense of stability in her life. Rather than trying to "uncover" Mrs. S's innermost feelings, the therapist tried to bolster Mrs. S's fragile sense of self and help her to develop a sense of connectedness with and control over her environment. Mrs. S's passivity began to be replaced by tentative testing of emerging autonomy. As she began to feel more secure about herself, Mrs. S also became increasingly able to engage in more stable patterns of interaction with her children. An especially difficult area involved Mrs. S's relationship with Susan. Helping Mrs. S to assume a parental role with Susan and set limits on her behavior was extremely difficult. Susan assumed that Mrs. S would take responsibility for the care of the infant, Tommy and he was left unattended repeatedly when neither mother nor daughter was able to deal with the unspoken issues which his birth represented.

The welfare of this infant became a major treatment issue, as he began to falter developmentally. While Tommy's birth had been uncomplicated and his Apgars were 8/9, the emotional neglect which he experienced began to exert a toll. At six months of age, Tommy had assumed an affectively flat demeanor. He averted his gaze even when efforts were made to engage him in a positive manner. Delays in motor development also began to emerge. While neither mother nor daughter wanted to surrender Tommy for adoption, the impact of their own emotional difficulties limited their capacity to parent Tommy. Furthermore, the issue of who was to serve as the parent needed to be resolved. Discussions around this issue were very affectively laden and therefore needed to be dealt with at a pace tolerable to Susan and Mrs. S. It was eventually determined that Susan needed to assume Tommy's caretaking responsibilities, and home visits began to focus on promoting positive attachment between mother and child. Susan was helped to learn to be responsive to Tommy's signals and to stimulate him in a way which he found to be pleasing.

Therapy with Cal focused on helping him to learn how to engage with his environment. When Cal appeared to "drift off" the therapist worked to re-engage him in more concrete activities. Use of fantasy play was discouraged, since Cal's overall orientation was much too inner-directed. When minimal structure was provided during therapy, Cal would become completely involved in doll play which seemed to reflect his exposure to physical and sexual abuse. Rather than serving to alleviate anxiety, these activities served to promote avoidance of a reality orientation. Therefore, Cal was engaged in activities designed to promote interaction and deal with daily occurences.

While the S family initially presented an overwhelming picture of psychological and environmental difficulties, the application of the transactional risk model during the course of intervention with this family did result in considerable gains. Mrs. S's increased sense of stability and capacity to utilize the support services being offered translated into improved consistency in her interactions with her two younger children. While her relationship with Susan continued to be a difficult one, recognition of this tension and ongoing efforts to help Susan parent her son continued. While less overt, some gains also began to emerge in her ability to recognize and respond to the affective needs of her children.

The gains evidenced by Cal during his treatment were quite remarkable in view of his initial presentation. Striving for autonomy replaced his early withdrawn stance and he began to interact more actively with his environment. Interestingly, Cal's decreasing passivity mirrored the gains evidenced by his mother in this area. Gains in language and cognitive abilities also accompanied Cal's progress in the emotional arena, with intellectual functioning in the low average range being revealed upon psychological re-evaluation. While the extent of difficulties experienced by this family require ongoing intervention, their capacity to respond to an intensive outreach program which also incorporated in-center therapeutic intervention is noteworthy.

From an intervention standpoint, the intense neediness and host of problems experienced by this family placed a significant stress on the interdisciplinary service delivery system. Initially, the classroom teacher was quite overwhelmed by Cal's passivity and inability to interact. His telegraphic references to chaotic occurrences in the home also caused frustration for the milieu staff, who questioned Mrs. S's therapist's commitment and/or ability to impact on the extent of dysfunction in the family. While Cal's entrance into play therapy was seen as a positive occurence, it was a short-lived respite from the intensity of staff feelings surrounding the difficulty in improving family functioning. Milieu staff "blamed" Mrs. S for her failure to provide a stable home environment and often felt that Cal should be removed from the home and placed in foster care. During these difficult periods, staff morale frequently faltered and various staff members were quick to blame themselves and their colleagues for failing to alter the extreme level of family dysfunction. In efforts to deal with staff feelings and prevent them from adversely affecting the overall course of intervention, frequent informal meetings were held among team members. Supervision and case conferences also were integral, as input from less affectively involved staff members could then be incorporated into treatment planning. It also was helpful to look back at these stressful periods once positive changes did begin to occur.

Implications for social policy and program development

Despite the magnitude of difficulties experienced by families such as those seen at Mt. Hope Family Center, few programs possess the integrated resources needed to impact on these dysfunctional systems. Rather, it is more common for families such as these to receive a host of services offered through various community agencies. In fact, it is not uncommon for a single family to have various members simultaneously involved with individual therapists in different agencies. While treatment is being provided, this lack of cohesion among treaters often contributes to the overall disorganization of the family system. Unless coordinated focused services are made available to these multi-risk families, an immense cost in terms of both human suffering and depletion of community resources will continue to occur.

While the costs associated with the provision of a comprehensive service model such as that recommended in this paper may appear to be prohibitive, in actuality a cost-benefit analysis may reveal such services to be cost effective. Since the consequences of maltreatment have been linked with juvenile delinquency, as well as with other emotional disturbances, prevention and remediation of the sequelae of maltreatment can have a major impact on reducing future depletion of service delivery systems.

Finally, in times of fiscal austerity, human services in general, including social and psychological services to maltreated children and their families, come under the scrutiny of budget-conscious government administrators and legislators. Increasingly, service providers are asked to document the beneficial impact of their service efforts. The inability to provide documentation through evaluation research reports and the like make the services in question more vulnerable to the budget-cutter's knife.

As we have illustrated, it is possible to utilize developmentally derived research in order to address the intervention needs of multi-risk maltreating families. Basic research on the consequences of child maltreatment on child development and family functioning potentially can contribute to the type of evaluation research needed to justify service dollars to skeptical administrators and legislators. In addition, this research can lead to the modification of ineffective programs so that we can better serve the need of maltreated children and their families. Unfortunately, the use of basic research by clinical, legal, and social policy decision-makers is unlikely without closer collaboration. Enhanced cooperation among these groups of professionals is in the long-term interests of better service and research on behalf of maltreated children and their families.

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Toward Tenacity of Commitment: Understanding and Modifying Institutional Practices and Individual Responses that Impede Work with Multi-problem Families

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Intensive work with multi-problem families can be immensely satisfying, but it is also emotionally and physically depleting, and at times unrewarding. While the despair and frustration of members of such families have been amply reported, the feelings of clinicians who work with these high-risk infants and their parents have received scant attention. I believe that it is important to look at two sets of feelings that practitioners who work with this population may experience—first, those feelings associated with the administration and supervisory structure of the settings in which the work is done, and second, those feelings that are elicited by children and parents themselves. Many such emotional responses can cause even an experienced clinician a great deal of discomfort, and, if denied, can seriously interfere with treatment. If, on the other hand, we can understand our own feelings and those of our colleagues and supervisees, we may be better able to support each other in the difficult work we do and to serve deeply troubled families with greater compassion and skill.

Because multi-problem families present such an array of difficulties, workers from a variety of disciplines may find themselves in one way or another involved with them. Thus, clinicians who work primarily with children whose biogenetic endowment is compromised are seeing an increasing number of organically impaired infants born to multi-problem families. Not only must additional services be provided for these infants and parents, but professionals in such fields as special education, occupational therapy, physical therapy, nursing, and speech, language and hearing also need to expand their conceptual and clinical framework in order to address the problems these families face. At the same time, many of us in the mental health professions are realizing the need to deepen our conceptual and clinical understanding of multi-problem families, particularly since we now realize that traditional psychological and psychiatric interventions have failed at the most basic level, that of developing and sustaining meaningful contact with members of these families.

Unfortunately, the service providers who are faced with meeting the range of interrelated developmental and parental needs presented by multi-problem families seldom have training beyond that required by their specific discipline, and have little access to new advances in developmental and clinical formulations. They have, in particular, little formal pre-service training or on-the-job guidance in recognizing, understanding, and ultimately using the powerful feelings that inevitably accompany work with this population.

Intensive work with multi-problem families can be emotionally depleting. If we understand our own feelings and those of our colleagues, we may be better able to support each other in this work and to serve deeply troubled families with greater compassion.

Confronting an array of difficulties

As service providers working with children from birth to three, we are charged with the challenging task of developing and implementing programs in a range of primary care settings for infants and their families.

These infants and parents fall roughly into two categories, with a great deal of crossover between groups. In one group are babies whose biogenetic endowment renders them developmentally vulnerable. Parents of these children are faced with the critical task of promoting optimal growth in their handicapped infant while concurrently attempting to work through their own complex responses to feelings of defect and deficit in themselves and their child.

In the second group are infants who are considered developmentally at risk due to serious limitations in their caregiving enviroment. These infants usually are referred for preventive intervention or for alleviation of the symptoms of developmental stress, distortion and delay they already exhibit as babies and toddlers. (Fraiberg, 1980, Provence and Naylor, 1983, Greenspan, et al., 1987). Additionally, these children may be organically impaired. The children in this second group belong to what are commonly described as multi-problem families. These families, designated also as hard-to-reach or multi-risk, are characterized by an array of individual, parental and environmental problems which call for new and creative approaches to meet their multiple, interrelated psychological and concrete needs.

As I have suggested, feelings associated with our work are of two types, related to the administrative and supervisory structure of the setting in which we work, and to the children and families we serve in one form or another. These latter responses may have to do with the feelings, impulses and ideas that are elicited in the clinician by the case material or by behavior reflecting the child's or parent's inner life. I will describe some

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of my own responses to a particular parent that contributed to an unsuccessful outcome because I did not understand them well enough at the time. Before I do that, however, I want to discuss feelings related to administrative and supervisory practice which also elicit responses that can profoundly affect our work.

Institutional practices

It is my contention that unquestioned institutional practices contribute all too frequently to feelings of futility and anger on the part of staff. Interestingly, clinicians' responses to the institutions in which they work are similar to feelings of hopelessness, helplessness, anger and despair expressed, usually behaviorally, by the families they treat. These responses are also similar to feelings of anger and futility we may have toward and about a particular child and parent at various points in the treatment process. (J. Fields, Yorburg and Turkel, 1970, Rigamer and J. Fields, 1971).

It is generally agreed that certain elements in any program have enormous influence on the overall attitudes and morale of staff. Provence and Naylor describe staff support as taking several forms including intellectual stimulation, an atmosphere of intellectual inquiry and curiosity, the ability to respond promptly to staff members' distress about problems with a parent or child, and provision of channels to address the inevitable strain that arises among people working together.

In most settings, however, inordinate and pressing demands upon administrators force them to subordinate their efforts to provide the climate of intellectual inquiry, training and empathy with staff concerns that Provence and Naylor suggest is vital to effective intervention. Beyond this, recent advances in the understanding of developmental processes have not yet been well integrated into the training components of many primary care settings. But with multi-problem families, the ability to conceptualize issues and treatment approaches is particularly essential for staff, adding a dimension that increases theoretical and clinical mastery. Without this dimension, staff feels at sea, puzzled by issues thay cannot understand or grasp, and dependent upon traditional interventions that at best address a few aspects of a multi-faceted problem.

As early as 1970, J. Fields et al. drew attention to another administrative dilemma—that the time needed for staff to understand and assess each family in depth, and to provide meaningful intervention over time, is incompatible with the inordinately high caseloads and extensive paperwork many agencies require. Seventeen years later, there have been no apparent changes in agency practice, and the question Fields and his colleagues posed then is equally relevant today. Since most of the families we see require more, not less time to address their multiple needs, why is it almost a matter of unquestioned policy to assign more cases to staff members than they can possibly manage?

As Fields, et al. suggest, one result of such practice is a staff that is often harried, overwhelmed, dissatisfied and unable to utilize their individual talents and knowledge. Administrators are forced to focus their energies on meeting the demands of funding sources and spend whatever time is left over meeting a variety of crises. Staff development and support necessarily falls lower and lower on their list of priorities. Supervisors are responsible for more cases than they can handle. In my experience, in all but a few demonstration settings, supervisory conferences of necessity consisted of highlighting the most critical aspects of eight or nine cases rather than an in-depth scrutiny of their theoretical and clinical issues. Case conferences as well tended to focus on management rather than on deepening conceptual and clinical understanding.

Additionally, the bureaucracy beyond the immediate work setting may negatively affect staff morale. For example, departments in many hospitals are run like small fiefdoms with little communication between disciplines. A physical therapy department without a social worker can refer a parent for mental health intervention—but then what? Unless the physical therapist and the mental health worker communicate informally or convene a special case conference, they often operate independently of each other, limiting effective intervention. Further, this fragmented treatment approach runs counter to new advances in developmental and clinical formulations that see development as involving multiple, interrelated pathways and needs that are most effectively addressed by a well integrated approach on the part of the individual practitioner and by the interdisciplinary team.

Caseloads that are too large, inadequate time for assessing and understanding each family in depth, insufficient intellectual stimulations, or training that does not encompass more recent formulations, and supervision that tends to be superficial, crisis oriented and limited in conceptual scope, along with a fragmented treatment approach, lead to the demoralization of both senior and junior staff. Feelings evoked are those of personal and professional inadequacy, incompetence, dissatisfaction, anger, helplessness, and despair.

Painful as these feelings are in themselves, the lack of their validation by administrators and supervisors can lower staff morale further. And it is often the case that overwhelmed administrators and supervisors, responsible for the overall program, feel criticized when negative feelings are voiced and therefore discourage their expression. Conflicts which arise among members of various disciplines as they attempt to work together can be another source of stress. These conflicts derive in part from honest disagreements about the best course to pursue in a given case, but just as often involve territorial or competitive feelings which are difficult to sort out in in the best of circumstances and almost impossible to resolve in the climate described.

Psychological factors influencing effectiveness

The discussion so far has focused on those elements in administrative structure and practice which can contribute positively or negatively to staff feelings of competence and selfworth. I want to turn now to psychological factors that have equal impact in affecting the overall effectiveness of staff.

It is my impression, shared by others (Rigamer and Fields; Fraiberg; Provence and Naylor), that these more elusive factors stem from countertransference issues that staff encounters in work with high-risk families.

The clinician's emotional responses require continual self-monitoring and attempts at self-awareness.

The term "countertransference" is meant by the authors cited, and by this author, to include all emotional responses on the part of the clinician toward or about the individual he or she treats. Further, it is generally agreed that countertransference, in this broad interpretation, is a factor in all levels of intervention in work with young children and their families, from home visits geared to the transmission of parenting skills to psychotherapy. Countertransference critically affects outcome. As Rigamer and Fields specifically note, the clinician's emotional responses require continual self-monitoring and attempts at self awareness. Indeed the clinician can make good use of these responses in work with multi-problem families but only to the extent that he or she is aware of them.

For example, some years ago I was assigned as the social worker for an 18-year-old woman whose baby was enrolled in the program in which I worked. Nancy was an angry and defiant young woman, prone to aggressive and sexual acting out. She tended to view people as all good or all bad, and had marked mood swings, reflecting a relatively primitive inner life and level of functioning. Many early developmental tasks had been poorly negotiated or not achieved. These traits also were reflected in Nancy's behavior toward her infant son. While she was not especially physically abusive, Nancy was extremely neglectful and both rejecting and overstimulating, depending on her mood. She found it difficult to allow David even the autonomy to explore a toy in his own way—he was to explore it "the right way," ie., her way or not at all. Further, although Nancy presented herself in crisis after crisis and seemed beset by inner and external stress, she frustrated all attempts to help her. She was unable, for instance, to keep appointments that would confer eligibility for public assistance, necessitating beginning the entire process again and again.

Soon after we met, Nancy began extolling my virtues to everyone in our center, to the extent that some of the other mothers began to express envious and competitive feelings. Needless to say, the tables soon turned and I became as despised as I had been admired, and Nancy did not hesitate to express these feelings about me either! What I had done, if anything, to incur such intense rage is still unclear. The important fact is that after my initial attempts to sort out Nancy's seemingly sudden change in feelings were met by continued hostility, I began to distance myself emotionally and even physically from her, avoiding going to the infant room, which I supervised, when I knew she would be there. First of all, I am embarrassed to admit, my pride was hurt. Although I had thought I had been well aware of the quixotic nature of Nancy's positive feelings for me, I realized a part of me had really warmed to her many compliments. More significantly, issues in my own history and inner life made me unrealistically afraid of Nancy. Her unpredictability, loose boundaries, highly charged emotions, and primitive level of functioning stirred up a complexity of uncomfortable feelings. My defense against these feelings was to distance myself and to view Nancy's situation and any possibility for change as hopeless. Not only did I view Nancy through this darkened lens, the entire staff began to complain about the futility of treating her and her child (an idea used by all of us to further justify minimum engagement). If I had been more aware, I might, at this point, have been an advocate for Nancy with day care staff, helping them to understand the roots of her behavior and planning with them some alternative, possibly more effective interventions with this young woman and her little boy.

It is important to mention that initially I was only half aware of my discomfort and only somewhat more aware of my wish to avoid Nancy. In addition, because of the urgency that surrounds our work, I had seven or eight other mothers who also needed my attention. I found myself thinking less and less about Nancy and increasingly about other, less nettlesome mothers and babies. More honestly stated, this shift in focus became a defense against scrutinizing my responses to Nancy. It took time to sort out the feelings described, and longer to understand how they might have interfered with treatment. The major point is that while it is uncertain whether or not Nancy could have formed a therapeutic relationship, my feelings may have contributed as much to the therapeutic stalemate as did Nancy's own characteristics.

Awareness of feelings: A catalyst for growth

I have described my experience with Nancy for two reasons. First, and most important, although I was unable to establish the kind of relationship with her that might have led to even incremental change, I learned about aspects of myself that became a catalyst for personal and professional growth. I have since worked with a number of mothers whose problems were similar to Nancy's. My work with them has been more successful not simply because I have become more clinically sophisticated or have additional years of experience, but because I am more aware of the inner forces which shape my particular responses toward these young women. Without careful monitoring of our own responses, including an awareness of the kinds of defenses we are likely to use in warding off uncomfortable or painful feelings, it is difficult, if not impossible, to distinguish between families with whom a therapeutic relationship truly cannot be forged despite all our best efforts, and those whose treatment is impeded by countertransference issues that are not well understood or even within our conscious awareness.

It is equally important, however, to consider institutional practices as they contribute to, and in some instances actually support typical countertransference problems encountered in work with hard-to-reach families. As Rigamer and Fields point out, in settings where the pressure for service and the urgency of need is great, it becomes especially easy to withdraw from individuals who are trying, or whose problems are chronic and seemingly "refractory to treatment." Unable to grasp the real nature of their problems and/or unaware of our own responses, we begin to share the hopelessness of those we seek to treat, become frustrated or angry at what looks like their stubborn resistance to our interventions, and feel there is little we can do. We begin to feel relieved when family members fail to keep their appointments and view their "recalcitrance" as further proof that intervention is futile. This sense of futility is often supported by the supervisor whose sense of annoyance with the therapist is only once removed from the family itself (Rigamer and Fields). Both therapist and supervisor eventually relegate such families to the bottom of their list with the tacit agreement that they are "unworkable." If this state of affairs continues, the family will resist whatever level of intervention is offered or will remove their child from the program. This all-too-frequent scenario contributes to a loss of self-esteem (not being able to adequately do one's job), and a sense of hopelessness, helplessness and anger in practitioner, supervisor, and administrator, who begin to blame each other and the family for the unsuccessful outcome. Since members of multi-problem families struggle with similar feelings, long before intervention is officially deemed a failure a pervasive sense of futility has most likely become an unacknowledged accompaniment to the therapeutic work, precluding the sense of competency and efficacy we want to feel about ourselves as clinicians and to impart to the families we treat.

Is improvement possible in the "real" world?

Most of us do not work in demonstration projects. On the contrary, we try to serve multi-problem families in programs that themselves face multiple problems. Given the fact that meeting institutional, administrative and clinical demands takes up most available working time, how can administrators promote an atmosphere of intellectual inquiry and emotional support among staff? How can administrators prepare themselves and their trainees to be more aware of their responses to agency pressures and to participating families? How can administrators help themselves and their trainees to cope with these feelings more successfully?

We do know that a climate of openness is conducive to promoting both intellectual curiosity and the expression of attitudes, feelings, and ideas. Creating such a climate presents a challenge to administrators, but I think it is a challenge that can be met, at least on some levels and to some extent. For example, I urge senior staff to think about how new advances in theoretical and clinical understanding can be conceptualized for staff in ways that apply to the problems they bring to supervisors or case conferences about a specific parent or child.

I also recommend that supervisors become more open in recounting to those they supervise, their own experiences with hard-to-reach families. The critical nature and special pressures inherent in our work often produce feelings of vulnerability in stafff about their own knowledge and skillls. In addition, as my experience with Nancy suggests, some of our responses to these families can cause a fair amount of discomfort. For both these reasons, it is important for trainees to hear about their supervisor's experience—blunders as well as success—and of the supervisor's struggle to make sense of the problems she or he faced in learning to work productively with these troubled families. In such a climate, less experienced staff might feel freer to ask questions and to express their own feelings, attitudes and ideas without fear of judgment. Just as traditional interventions with multi-problem families need to be modified or expanded in scope, traditional modes of supervision also may need modifying with the aim of facilitating the kind of dialogue between supervisor and supervisee that helps the latter to understand and feel comfortable about a range of responses. The degree to which this can be accomplished depends in large part upon the supervisor's ability to accept disturbing feelings in him or herself and others.

I want to end on a note of encouragement. Probably the most helpful analogy I can make to work with multi-problem families is that of raising children. This analogy rests not on the attributes of the individuals we are trying to help, but on the degree of commitment needed. Just as parents must be able to sustain their relationship with their growing children through difficult emotional times, so clinicians need to pursue their relationship with members of multi-problem families despite moments when a complex of negative or ambivalent feelings threatens the integrity of the therapeutic bond. This commitment is in itself rewarding. The tenacity of this commitment can often bring, in its wake, meaningful environmental and psychological change.

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Working with Infants, Toddlers and Their Families: What We Do and How We Keep Going

At the February, 1987 regional conference, "Vulnerable Infants, Stressed Families: Challenges for Research and Practice," co-sponsored by Project Zero to Three of the National Center for Clinical Infant Programs and ten California public and private agencies serving young children, four individuals whose combined experience adds up to almost a century of clinical work with infants, toddlers and their families were asked to reflect on just what it is that they do and—equally important—how they keep going in the face of the many uncertainties and frustrations that confront all of us in this field.

For Geneva Woodruff, Kathryn Barnard, Sally Provence and Jeree Pawl, "what we do" involves direct clinical work with infants, toddlers and their families; research; pre-service and in-service training; writing; advocacy; and a constant search for resources. We hope that their insights into the challenges and rewards of our field will help others to "keep going" in their work.

The Editors

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Two relatively straightforward questions, "What do you do?" and "What keeps you going?" each could be answered in several ways, depending upon whether I am being asked: 1) what I'm funded to do, or 2) what I actually do, and 3) what continues to motivate me both personally and professionally to work in early intervention, especially in light of the yuppie mentality of "you can't be thin enough or rich enough" that has swept America.

Rather than assume the intention of the asker, I will address all these possible questions as briefly as possible.

What am I funded to do?

Currently I direct two federally funded projects, Project KAI and Project WIN. Project KAI is a national training program designed to provide in-service training and consultation to early intervention programs in the areas of child development and family systems, transdisciplinary teaming and transagency coordination. In the past ten years the training staff and I, under the auspices of several different sources, have provided 3-6 days of intensive on-site training to over 210 teams across the country and abroad. We have provided training on-site because we believe that a trainer can have the most influence by working with people at their work place over several days and by offering them the time and support necessary to identify their own service issues. It is only then that service providers decide how they would like to change, modify and refine their service delivery system. Overall, our training project has been very successful, as evidenced by the fact that over 70% of the projects we have trained have invited us back for follow-up training.

The second project I direct, Project WIN, is a direct service project for young children of intravenous drug users, who are at risk for or have been diagnosed with AIDS. The goal of the WIN project is to provide comprehensive community-based services for these families in both a center-based and home-based program. A primary service goal of the project is to provide services which make it possible for families to care for their children at home, rather than solely in the hospital. Presently many children with AIDS are being left in the hospital because family members may themselves be symptomatic of AIDS or feel overwhelmed by the prospect of caring for a sick child with little community support. In addition, a family that knows that a child has AIDS may resist caring for the child at home because they fear social isolation, discrimination and hostility in their communities.

Because little is known about children with AIDS, a major educational goal of the project will be to disseminate information to the public and professionals about the needs of these children and their families, as well as successful practices for helping them. We hope to accomplish this goal in part by coordinating services for the children and families through a transagency board comprised of representatives from 21 Boston agencies. At monthly meetings, the representatives of city and state agencies, pediatric divisions of major medical institutions, as well as health, education, drug treatment and social service agencies will set policies, monitor procedures and oversee the case management and coordination activities for the WIN Team.

What do I actually do?

All in all, I do very little clinically. Much of my time is spent keeping things going and trying to insure that there will be life after the present funding runs out. Typically, much of my day-to-day time is spent in planning meetings with staff, public relations efforts, marketing, training and looking for funding, writing grants, and meeting and negotiating with funding sources in both the public and private sector. For example, last year we responded to ten requests for proposals, of which four were funded. Clearly this is not a batting average to write home about. I would lie if I did not admit to the fact that living on soft money and being responsible for ten professional staff members and myself, the rent, operating costs and indirect costs to my fiscal agency, is at times terribly anxiety-producing and worrisome and borders on the feeling of professional suicide.

Even when I do receive funding, there is always an element of feeling like a survivor of the Holocaust because I know that many of my worthy colleagues have lost out in the same competition. There have been times in those final weeks and hours of waiting for the verdict of whether or not we have been funded that I have sworn that, if approved, this will be my

David Kreider

last grant. Definitely, I promise myself, at the end of the funding period of these grants I'm going to get myself a real job with real security. However, once we are funded and on our way, these thoughts subside. In some ways it's a little like the pain of childbirth: once the baby is born, thoughts of the harrowing delivery become distant and fade with time. All in all, though, I guess living on soft money must suit my personality. I suppose I like the excitement and when successful, the risk, the opportunity to be innovative and creative, and the intensity of completing a usually overambitious workscope. And you must admit that there are few professionals who get the challenging opportunity to restructure their workscope and working environment every three years. As a working process the world of grants does require staff to be accountable and productive; in my opinion these are important values of the work environment, especially in human services.

How do I keep going?

What really is the most compelling aspect of the field for me personally are the people—both my colleagues and the families we serve. Through years of associations with professionals in the field in training, sitting on boards, planning conferences, etc., I have made many deep and lasting friendships. As with all friendships, we have seen one another's families grow, we have supported one another through our personal tragedies of divorce and losses, and we have applauded each other's accomplishments of a well-earned degree, a promotion, a new spouse, baby, grant, etc. There probably isn't a major city in the United States today in which I couldn't call a friend from the field, or a friend of a friend to have dinner or to meet after work.

If professionally our purpose is to make a difference, to have an impact, the field has offered me many opportunities in training, and in influencing policy and legislation. I am always proud to say what I do. Working with children and families is important and good work. I also feel honored to have the opportunity to serve as an advocate and a service provider for families and young children who justly deserve service. I do feel, despite the hassles of getting and providing services, that it is always worth it when a family expresses their appreciation for the work we do and the importance we play in their lives. If Dale Carnegie is right in his book *How to Win Friends and Influence People*, that feeling important is a key motivator for people, I must admit that I do feel the work I do is important. I've also always felt fortunate to be part of such a worthy field and to work with so many fine professionals.

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As we think together about the struggles and rewards of working with infants, toddlers and their families, an historical perspective can be helpful. Most of us still need to worry about where the money for our programs will come from for next year, for the next three years, for the next special project or piece of research we want to do. Our services are not yet incorporated into the structure of the "system"—but sometimes our work *does* get incorporated into the values of the larger society. This has happened for Project Head Start. It must happen for services for infants, toddlers and their families.

> *I have spent the past fifteen years trying to understand the complexities of the earliest years of life. Two mottoes have helped to guide me. First, infants can't wait. Second, all parents want to be good parents.*

I have spent the past fifteen years trying to understand the complexity of the earliest years of life, particularly for the high-risk infant and the high-risk family. Two mottoes have helped to guide me in this work.

First, infants can't wait. Infancy is an extremely important period in human development. The patterns of the child's behavior and the patterns of caregiving established in infancy do have a long-term impact.

Second, all parents want to be good parents. I have found this to be true despite the fact that lack of knowledge and/or poor experiences in their own lives may impede parents' efforts to care adequately for their children.

As I think ahead to goals for future research on preterm infants and high-risk, insecure families and for services that will help such infants and families move ahead, I am convinced that we all must be brave, courageous and forceful as we carry on our work. Yes, we face many unsolved problems, but we also can have a vision of ways in which the human condition can be improved. We need "front load pay" programs, service delivery systems that will invest money in early prevention programs rather than waiting to pay—dearly—for the tragedy of disordered lives. We need to do a more creative job of selling the concept of prevention and to advocate for prevention services at the national, state and local level.

We must recognize that a social revolution is before us. In the state of Washington we are addressing the gigantic task of welfare reform, attempting to re-think our societal treatment of poor families and to avoid the recycling of poverty. As a nation, we need to think about how to support the development of normal, disadvantaged and handicapped children, more and more of whose parents are working outside the home. Day care must be on the national agenda. Foster care must be there too. And whenever we plan alternative care for children we must be aware of the major risk of replacing undesirable conditions in the home with undesirable alternative care that also fails to support healthy development.

Health and education professionals must beware of service models that attempt to handle complex problems in too short a time with insufficient resources. We must be more realistic about the programming, time and energy necessary to ameliorate high-risk conditions.

Something that "keeps me going" as we face these major public policy challenges is the excitement of participating in research and in the translation and dissemination of knowledge to colleagues who are in the front lines of practice on a daily basis. There is a wonderful feedback loop for people involved with infants, toddlers and their families: we can study and research problems, test our hypotheses in the field, and get new ideas from our clinical work. When do my biggest learning experiences occur? When I *don't* get the answers I want!

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I have borrowed from a colleague a phrase that sums up many of my reflections on work with infants and their parents. That phrase is "failings and thrivings"—it says a good deal about our daily work and about our field.

When I got into work with infants in the late 1940s, there was considerable suspicion surrounding anyone who wanted to spend much time trying to understand and study babies. After all, what could they tell you? What could they say to you? Were they really "with it" anyhow? Babies are just babies—why should you waste your time? Pediatrics already had the reputation of being about "little problems of little people." Pediatricians were never considered quite as good as internists. The farther you got down the age scale, the lower your status, and this was doubled in spades for infants. That one could have a real interest in studying babies was mystifying to most of the field, with a few exceptions.

In the late 1940s and early '50s I had a unique opportunity. I was participating in a study of infants in institutions, and in a longitudinal study of healthy personality development, and also was providing consultation concerning children with developmental problems on a hospital ward. These three activities, which occupied my full time, kept me in such a state of fascination that I never got over it. I never *was* able to get beyond the early years in my professional focus—except, of course, for my interest in and concern for parents.

Those of us who work with infants all share a feeling of wishing to set things right, to be a healer, to bring comfort, to relieve pain, to change things for the better.

I was glad to see an interest in infants gradually become more respectable. I was pleased, for example, when those responsible for training child psychiatrists realized that child psychiatrists ought to know *something* about the early years—children three, four and five years old, and now even infants. It has been gratifying to see this acknowledgment of the importance of knowing first-hand about infancy and early childhood.

Those of us who work with infants all share a feeling of wishing to set things right, to be a healer, to bring comfort, to relieve pain, to change things for the better—that's a part of what attracts us to this work. The intellectual interest, the fact that there is always something new to learn is compelling too. Sharing with one's colleagues and with students is enormously important and even though we are often glad to hand a baby back to the parents after a session and to retire to our offices for a quiet minute or two, there is the pure *pleasure* of being with babies and those who love them.

I have always said to my colleagues, to my students, and to myself that if there ever came a time when I thought there was nothing more to enjoy, to learn, to be challenged by, to wonder about, that would be the time to quit. Before that happens, I will be well over the hill, and I expect never to reach the point where there is nothing interesting to see and to know about with infants.

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Sometimes I feel I can't bear to try to describe or explain what I do to one more person. I don't feel I ever *really* get it right. For example I have been trying for fourteen years to explain it to an aged aunt in response to her semi-annual query "What do you *really* do?" About half way through each new effort with my aunt, we are always interrupted by our need to listen to her current parakeet's newest speech acquisition. It always sounds suspiciously to me like the last one, which I *also* couldn't understand. Apparently it's a draw. I can't understand what my aunt insists her parakeet is saying and she still doesn't understand what I do.

Surely the task is easier here because all of us, each in his or her own way, are doing many of the same things. Our hope is that our work with parents and infants will make things better *between* them and for *each* of them. We do it because we feel that professionally there is no more important thing that we could be doing.

Over the years, the infant mental health program with which I work in San Francisco has come to deal primarily with parents who are truly living life on the edge. These are people whose lives are chaotic and whose histories are primarily a map of pain and adaptation to that pain. Their lives stun us with their bleakness, their boredom, their harshness and their hopelessness. When we visit them in their homes, the realities of their lives assault all of our senses. We struggle to find a way to make a relationship with them which will have in it some trust and some glimpse of hope. We try to offer them a gentler route to programs and services which we feel might be helpful. We offer them our close attention, our concern and our understanding—but we are as helpless as they are to offer the social changes that might actually ease their days.

As we can, we help them learn about their child—how she is like and unlike other children—and we try to help them come to appreciate how, for their child, they are the heart of the world. We do this only as it seems that they may hear it—when some look, some need or some question informs us that at this moment what we say can matter to them. If in hearing about their lives, then or now, we can trace a path with them that bears on their feelings toward their child, on how she is experienced , we will do it. We try to temper the darker things expressed in their relationship with their child and to enhance what good things we can observe. We are, I hope, patient and realistic. If we are not we will not see them again. And even if we are we may not, for though their lives are lived as on mired treadmills they do not quiet long enough for them initially even to remember us. It takes time for what we do together to matter to them.

This kind of work would be impossible to do without the constant revitalization from colleagues. One could quickly feel as helpless, angry and abused as those we seek to help. Our program staff not only has one another but we also have a training program. From our need to teach comes an enhanced impetus to learn and to think. From what each trainee brings *with* them, we also learn. This space to reflect and think is life-giving and although thinking is in itself a joy you simply can't avoid it when you are asking so much of new people. You owe them your best and in giving it you are yourself renewed, continue to learn and thus survive. We are available to each other and take care of each other as well as we can, and we laugh a lot.

This kind of work would be impossible to do without the constant revitalization from colleagues.

Personally, I feel fortunate that my very first experience as a graduate student—suffering as I did from the delusion that if I simply passed through an acute ward the catatonic would dance and the mute, sing—was, in fact, with a severely autistic in-patient girl, age 3½. I learned early to be content with small changes, to appreciate and value them, and to be suspicious of the powers attributed to mothers both to create perfect health and to maim irretrievably.

I admit that I was not courageous enough in those early years to voice my inchoate discomfort with the latter view but I will take credit for genuine total skepticism. When I spoke with the mother of the child I saw, it was hard for me to believe—despite what I was being told—that this ordinary, gentle and loving woman who was successfully raising 6 other children could have been so transformed around the raising of her fourth child as to render this child, single-handedly, mute, and disconnected—a whirling and spinning child whose eyes, if they met yours, looked not into them but weirdly through them. Besides, this woman wasn't even obsessive-compulsive, intellectual and cold as she was supposed to be, and the father was a warm-hearted, intelligent farmer—but then of course he didn't matter anyway. It all did make me wonder, and it *certainly* made me wonder who this child could have been to begin with.

As for the child herself—my presence did not create a miracle. Whatever powerful fantasies had driven me into the field were surely eroded as I struggled to find a way that she might notice me—or maybe feel me. After a year many things had evolved between us. She was deeply invested in my placing small sections of her body into a doll house rocking chair and then singing about those body parts as they were rocked—elbows, ears, toes, knees. She loved that game. She would rather do that than whirl or spin or lick the wall.

We had been playing this game for some time one day when our time was up. She kept not wanting to leave. She sat on the floor, her hand in a loose fist over the rocker, whining and grumping. I was telling her that we couldn't rock her knuckles right now. And I was trying to describe the sequence of events that we would now pass through. She was stuck. I was stuck. Then I said, "You know, Martha, you can take them with you—they're yours, you know—they're with you all the time." She quieted, put her right knuckles and hand carefully into her left and rose to her feet. Her face was transfigured. We made our way to the ward and as we entered she went up to a childcare worker. She raised her bunched hand toward him, smiled and said her first word, "Uckles." And it had only been a year. It meant a great deal, but it was such a little thing and it had taken so long.

Small changes in the relationship leave room for infants to experience the world as good, when it is, and for different kinds of relationships as possibilities.

Unwittingly, it was splendid preparation for working with our families, for we must know that infants bring their own powerful, unique selves to the situation and we need to respect that. We need to know that the work is slow and arduous and that small things may mean a lot. Although we sometimes achieve splendid results, the belief in the importance of modest changes is a necessary one. For though we all believe in the possibility of change, there would be no way to work with many of the people we do if we imagined that remarkable transformations were the only things which could matter. One cannot erase their histories. But from the point of view of the baby, small changes may in themselves make large differences and, more important, they may preserve future possibilities.

The experiences that we have are gradually organized into complex expectations. In the best of situations these are expectations that promise richness and goodness, the safety of exploration and expression and the safety for imagination and pleasure. In the worst they translate into an expectation and preparedness for what is essentially danger. When adaption from the beginning is almost solely the infant's task, efficiency alone will ensure that the infant will conserve and restrict, narrow and even freeze, those expectations—always prepared, always on guard. Gradually what we actually receive from the world shapes not only what we *expect* to receive but what we *perceive* we receive. It is an extension of the uniqueness of our perception at birth, and in this way we are the continuous mutual creators of our own experience. For the small child for whom this demand for continual massive adaptation is unremitting and harsh (and for most of these children it is, both in the moment and over time) there will finally be no other way to experience the world. The child's view becomes one of an unshifting reality. The world is cast in a darkness through which light and color can no longer be seen even as they exist. Increasingly, risks are, finally, not to be taken.

If such early experiences are ameliorated as they are happening—even in small ways—the opportunity exists even for the child who remains in a basically dismaying relationship to have a less rigid and more promising way to experience the world. I think of those improvements—those small changes in the relationship—as creating spaces in an internal structure which leave room for experiencing the world as good, when it is, and for different kinds of relationships as possibilities. We say, when a patient whom we observe as a severe character disorder shows some surprising spark of promise, "There must have been something or someone or *that* could not be there." For these infants and toddlers these changes and shifts in their relationship with their parents *are* that "something" or "someone." A baby who is *sometimes* seen as good, who is smiled upon, and whose needs are noticed sometimes has a world available to him in the moment, and experience *still* available to him, that he would not have were he to continue to be perceived unrelentingly as bad, irritable, rejecting or incessantly demanding. With our intervention, many possibilities remain. This, I think, is what I do—although I have never tried *this* one on my aunt and I think I may hear a parakeet.

Recently, Elizabeth Browning, who is one of our trainees and a poet in her own right, was discussing with me her first visit to a mother and child. The mother, Choya, is 34 years old, unmarried, and lives with her first-born, month-old daughter in a hotel room. Choya is toothless, unhealthy-looking, and covered with the kind of street tatoos that look as if a small child had been given permission to meander aimlessly and at will with a purple marker on all visible skin. Elizabeth's notes, from which I will quote, tell us that Choya began recounting the story of her childhood. Choya's mother had given her up at birth. ("You know Catholic priests in them days said,—go on and have as many babies as you can.") Her mother had 10 babies. Choya was in numerous orphanages and foster homes, "Yeah and I got beat up a lot, real bad." She was adopted at nine by a lady who wanted to change her but, as Choya said, "It was too late, see. I was already myself. I couldn't change." This woman locked her in her room, beat her and didn't feed her much. Choya sometimes escaped by climbing out of a window ("I guess that's why I love animals, see, I used to get into the dog's kennel to keep warm.") Elizabeth said, "That sounds awfully rough on a little girl." Choya nodded sadly and said, "Yeah, I've been hurt a lot. I've been hurt too much see? I don't let anyone matter to me no more. I don't let them get close, see? I can walk away from anyone and not lose a wink of sleep."

Elizabeth said, "It must seem to you that if you trust anyone and let them get close they will hurt you." "Yeah," said Choya, and she looked at Elizabeth. Elizabeth said, "It must be hard to have a little baby who is dependent on you when getting close to someone feels so dangerous." Choya said, "Yeah, but you know, I don't think she even *likes* me."

Clearly, Choya is indeed "already herself." Her baby is already herself—but a self still very much in creation. Elizabeth has her work cut out for her. You and I have our work cut out for us. Let the work begin.

Perspectives on Practice

The Child Development Project: A Model of Medical—Educational Collaboration

by
Margot Kaplan-Sanoff, Ed.D.
Steven J. Parker, M.D.
Barry Zuckerman, M.D.
Child Development Project
Boston City Hospital

Independently and in combination, factors associated with poverty impair children's development and behavior. Medical factors (e.g. prematurity, low birth weight, lead poisoning, in utero exposure to alcohol and psychoactive substances) and social factors (poor maternal education, stress, maternal depression and drug use) occur more commonly among children living in poverty, and often lead to developmental delay or disturbance in young children. Pediatricians and pediatric nurse practitioners who care for poor children frequently express concern regarding the developmental progress of many of their patients. They talk about a withdrawn 18-month-old with little affect or positive response to toys, or a three-year-old still speaking in two-word phrases. Yet time and budget constraints, combined with inadequate background knowledge in child development, prevent them from determining the type and extent of the child's problem, making an appropriate referral, and ensuring compliance with it. Children with easily identifiable developmental problems such as birth defects, cerebral palsy, or multiple handicaps usually receive appropriate and timely services. However children with more insidious problems such as language delays of six to ten months, social immaturity, or scattered development are more difficult to identify. Furthermore, the medical practitioner is often unsure which of these children need intervention because the outcome for these problems is varied. Follow-up visits several months later frequently demonstrate that these children are neither progressing nor receiving help for an increasingly serious delay in development that will eventually require special education services.

Having repeated these experiences for years, pediatricians at Boston City Hospital turned to early childhood educators for help. The Wheelock College Graduate School joined them in creating the Child Development Project, a multidisciplinary team of pediatricians, educators, and therapists who conduct developmental assessments and coordinate referrals for children from birth to age five. Funding came from the Jessie B. Cox Charitable Trust and The Boston Foundation. From the initial writing stage of the proposal through implementation and dissemination of information, this collaboration has served as a model for an efficient creative response to the developmental needs of young disadvantaged children.

The premise of the Child Development Project is that children living in poverty and suffering from a health problem are at high risk for mild to moderate developmental disabilities, behavioral impairment, and subsequent school failure. In order to prevent these poor outcomes, the goals of the project are: 1) to identify children with developmental delays and disturbances, 2) to insure treatment for these children by referral to appropriate services, 3) to influence policy decisions in Boston regarding young children with developmental problems, and 4) to serve as a model of medical-educational collaboration for other municipal hospitals.

Subjects and Predicates

Rather than risk losing patients by establishing a new clinic with its own appointment and management procedures and space demands, the Child Development Project operates at the site where children already receive their health care. Children admitted to Boston City Hospital's inpatient wards are seen routinely. All children visiting the hospital's Lead Poisoning Clinic, Neurology Clinic, Failure-to-Thrive Clinic, Teen and Tot Clinic, and Sickle Cell Clinic are seen because of the assumed high incidence of developmental disturbance among patients. Project staff also conduct monthly on-site assessments of preselected children at Neighborhood Health Centers and Head Start programs. Early childhood specialists from the Project are members of each clinic or health center team; they exchange information with the medical staff at meetings and on rounds. In this way, Project staff use the already existing resources of the health care site to best serve the children.

Areas of assessment

Directors of local early intervention and special education programs agreed that it would be a waste of time and resources for the Project staff to conduct in-depth developmental testing for all children since programs conduct their own battery of tests on any child referred to them by the Project. Thus, the Child Development Project's assessments consist of

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We thank Linda Gilkerson, Ph.D. for her help in the early development of the Child Development Project.

National Center for Clinical
Infant Programs

5th Biennial National Training Institute

"Frontiers and Frontlines: A Decade of Strengthening Infants, Toddlers and Their Families through Research and Practice"

WASHINGTON, D.C., DECEMBER 4-6, 1987
J.W. MARRIOTT HOTEL

REGISTER NOW

CELEBRATE

The Tenth Anniversary of the National Center for Clinical Infant Programs
Gala Anniversary Dinner

Washington, D.C., December 3, 1987, J.W. Marriott Hotel

The National Center for Clinical Infant Programs is celebrating the tenth anniversary of its founding in 1977 with a national training institute and a gala anniversary dinner.

The anniversary dinner on the evening of December 3, chaired by T. Berry Brazelton and Amy Cohen, will bring together professionals, members of the business community, policymakers, parents, philanthropists and national celebrities to honor the achievements and benefactors of the National Center's first ten years and provide support to address new challenges. Institute participants are urged to attend if they can, to help celebrate the achievements of NCCIP and of all whose work concerns infants, toddlers and their families.

PARTICIPATE

The fifth biennial national training institute will reflect NCCIP's multidisciplinary, multidimensional perspective on the earliest years of life. The institute title, "Frontiers and Front Lines: A Decade of Strengthening Infants, Toddlers and Their Families through Research and Practice," reflects the National Center's commitment to translate new knowledge into policies and practice that effectively support families with young children. In order to offer training institute participants opportunities to stretch their understanding beyond their own discipline or work experience, NCCIP will bring together the perspectives of professionals from many disciplines, of parents, of researchers, and of policy makers. Plenary sessions, pre-institute seminars, invited special interest sessions, as well as symposia, poster presentations and videos selected from a nationwide call for proposals, will address normative development and environments and infants and families at risk, with the conviction that greater understanding of one area sheds light on many others. Continuing education credits for physicians, psychologists and nurses have been applied for.

PRE-INSTITUTE SEMINARS

Friday, December 4, 9-11:30 a.m.

A. Funding opportunities for research and services—representatives from federal and state agencies and foundations concerned with children from 0-3 and their families

B. Concepts in infant mental health (designed for participants with non-mental health backgrounds)—**Steven Seligman, D.M.H.** and **Judith Pekarsky, Ph.D.**, San Francisco General Hospital, University of California, San Francisco

C. Issues in implementing P.L. 99-457, the Education of the Handicapped Act Amendments of 1986—Samuel Meisels, Ed.D., University of Michigan, Ann Arbor; **Kathleen Kirk Bishop, D.S.W.** and **Merle McPherson, M.D.**, Division of Maternal and Child Health, DHHS and **Philippa Campbell, Ed.D.**, Office of Special Education and Services, Dept. of Education

D. Frontiers of attachment research—Mary Main, Ph.D., University of California, Berkeley; **Vicki Carlson, Ph.D.**, Washington University, St. Louis; **Jude Cassidy, Ph.D.**, University of Virginia; **Carolyn Eichberg, Ph.D.**, Regional Center for Infants and Young Children, Rockville, Maryland; **Nancy Kaplan**, University of California, Berkeley; **Donna Weston, Ph.D.**, University of California, San Francisco

E. Infants, parents, professionals and AIDS—Margaret Heagerty, M.D., Harlem Hospital, New York CIty; **Geneva Woodruff, Ph.D.**, Project WIN, Brighton, Massachusetts

F. Strategies for parent/professional advocacy for state-supported services for infants, toddlers and their families—Wendy Lazarus, Southern California Children's Health Network, Santa Monica; **Marla Mack,** Wichita State University, Wichita, Kansas; **Rosalie Streett,** Friends of the Family, Baltimore, Maryland

G. Designing and sustaining longitudinal research with infants and families—Jack Shonkoff, M.D. and **Penny Hauser-Cram, Ed.D.** University of Massachusetts Medical Center, Worcester; **Kyle Pruett, M.D.,** Yale Child Study Center, New Haven, Connecticut

H. Working with multirisk families: forming partnerships and coping with stress—Barbara Fields, M.A., C.S.W., Larchmont, New York: **Barbara Ivins, Ph.D.,** Children's Hospital, Oakland, California; **Alicia Lieberman, Ph.D.,** San Francisco General Hospital, University of California, San Francisco

I. Whose child is it anyway? Supporting young children and their families in the face of chronic illness—Joy Goldberger, Johns Hopkins University, Baltimore, Maryland; **Robin Thomas, R.N., Ph.D.,** Children's Hospital and Medical Center, Seattle, Washington

J. A family systems approach to early intervention—Carl Dunst, Ph.D., Western Carolina Center, Morganton, North Carolina

K. Follow-up of infants exposed prenatally to drugs: a service model—Judy Howard, M.D., Vicki Kropenske, PHN, R.N., and **Rachelle Tyler, M.D.,** University of California at Los Angeles Medical Center

L. Neurobehavioral assessment of preterm infants: implications for care—Heidelise Als, Ph.D., Children's Hospital, Boston, Massachusetts

M. Physiological assessment in infancy-Nathan Fox, Ph.D., University of Maryland; **Stephen W. Porges, Ph.D.,** University of Maryland; **Stephen J. Suomi, Ph.D.,** National Institute of Child Health and Human Development, Bethesda, Maryland

N. Assessing the sensory integration of infants and toddlers: implications for intervention—Patricia Wilbarger, OTR, M.Ed., Regional Center for Infants and Young Children, Rockville, Maryland

O. Adaptive coping of infants and toddlers: Assessment and intervention using the Early Coping Inventory—G. Gordon Williamson, Ph.D. and **Shirley Zeitlin, Ed.D.,** John F. Kennedy Medical Center, Edison, New Jersey

P. The Connecticut Infant and Toddler Developmental Assessment (IDA) Program and the Parent Infant Observation Guide: Training professionals and paraprofessionals to assess infants and families—Susan Epperson, M.Ed., Department of Health, Hartford, Connecticut; **Joanna Erikson, M.P.H.,** Yale Child Study Center, New Haven, Connecticut; **Candice Percansky, M.A.** Ounce of Prevention Fund, Chicago, Illinois; **Victor Bernstein, Ph.D.,** University of Chicago

Q. Clinical diagnosis in infancy: models and current issues (for experienced practitioners and researchers)—**Stanley Greenspan, M.D.,** George Washington University Medical School; **Robert Harmon, M.D.,** University of Colorado Medical School; **Serena Wieder, Ph.D.,** Regional Center for Infants and Young Children, Rockville, Maryland

R. Introduction to the strategy of assessment of parent-child interaction: The NCAST scales—Kathryn Barnard, Ph.D., R.N. and **Georgina Summer, M.N.,** University of Washington, Seattle

S. New models for collaborative parent/professional training—Nora Wells, Federation for Children with Special Needs, Boston, Massachusetts, and **Florene Poyadue,** Parents Helping Parents, San Jose, California

PLENARY SESSIONS

Plenary sessions will reflect themes central to the perspective of the National Center for Clinical Infant Programs. This perspective emphasizes: 1) individual differences in infants and families, with a recognition, however, that all infants and families have many needs in common; 2) the interaction and intersection of multiple lines of development in the growing infant or toddler; and 3) the importance of relationships—between the baby and its partners, among family members, and between the family and its support system.

Friday afternoon, December 4

Opening plenary session: **Individual differences, universal needs: findings from 25 and 30-year follow-up studies of infants—Virginia Demos, Ed.D.**—Harvard University, Cambridge, Massachusetts; **Emmy E. Werner, Ph.D.**—University of California at Davis; Chair: **Jeree Pawl, Ph.D.**—San Francisco General Hospital, University of California at San Francisco

Saturday morning, December 5

Plenary session: **Facilitating motor control and emotional growth in infants and toddlers—G. Gordon Williamson, Ph.D.**—John F. Kennedy Medical Center, Edison, New Jersey; **Stanley I. Greenspan, M.D.**—George Washington University Medical School, Washington, D.C.; Chair: **Linda Gilkerson, Ph.D.**—Evanston Hospital, Evanston, Illinois and Erikson Institute, Chicago, Illinois

Luncheon, Saturday, December 5

Dialogue: What is helpint?—**Carl Dunst, Ph.D.**—Western Carolina Center, Morganton, North Carolina; **Florenge Poyadue**—Parents Helping Parents, Inc., San Jose, California; **Gina Barclay-McLaughlin**—Center for Successful Child Development (Beethoven Project), Chicago, Illinois; Chair: **Judith Viorst**—Author, Washington, D.C.

Saturday afternoon, December 5

Plenary: **Influencing and interrupting cycles of maladaptation: Insights from attachment and object relations theory and research—Mary Ainsworth, Ph.D.**—University of Virginia, Charlottesville, Virginia; **Mary Main, Ph.D.**—University of California at Berkeley; **Sally Provence, M.D.**—Yale Child Study Center, New Haven, Connecticut; **T. Berry Brazelton, M.D.**—Children's Medical Center, Boston, Massachusetts; Chair: **Joy Osofsky, Ph.D.**—Louisiana State University Medical Center, New Orleans, Louisiana

Sunday morning, December 6

Plenary: **Child care for infants and toddlers: Research issues and agenda—Ellen Hock, Ph.D.**—Ohio State University, Columbus, Ohio; **Carollee Howes, Ph.D.**—University of California at Los Angeles, California; **Theodore D. Wachs, Ph.D.**—Purdue University, West Lafayette, Indiana; Chair: **Kathryn Barnard, Ph.D., R.N.**—University of Washington, Seattle, Washington

Closing plenary: **Taking responsibility for infants and toddlers: A policy perspective—Irving Harris**—Ounce of Prevention Fund, Chicago, Illinois; **Jule Sugarman**-Department of Social and Health Services, State of Washington, Olympia, Washington

SPECIAL INTEREST SESSIONS

Invited special interest sessions will be held on Friday afternoon, Saturday morning and Saturday afternoon. Presenters will include: **Kathryn Barnard, Ph.D., R.N.,** University of Washington; **Leila Beckwith, Ph.D.,** University of California at Los Angeles; **Roseanne Clark, Ph.D.,** University of Wisconsin; **Karen Freel, M.S.,** University of Chicago; **James Garbarino, Ph.D.,** Erikson Institute, Chicago; **H. Joseph Horacek, M.D.,** University of North Carolina, Chapel Hill; **Daniel Kessler, M.D.,** New York Hospital-Cornell Medical Center; **Gunhild Kestermann, Ph.D.,** National Institute of Child Health and Human Development; **J. Ronald Lally, Ed.D.,** Far West Laboratory for Educational Research and Development, San Francisco; **Alicia Lieberman, Ph.D.,** San Francisco General Hospital, University of California, San Francisco; **Edgardo Menvielle, M.D.,** Children's Hospital National Medical Center, Washington, D.C.; **Dolores Norton, Ph.D.,** University of Chicago; **Kyle Pruett, M.D.,** Yale Child Study Center, New Haven, Connecticut; **Rebecca Shahmon Shanok, Ph.D., M.S.W.,** Jewish Board of Family and Children's Services, New York City; **Ann Turnbull,** University of Kansas; and **Fred Volkmar, M.D.,** Yale Child Study Center, New Haven, Connecticut. In addition, presenters at the Friday afternoon and Saturday morning plenary sessions and at the Saturday luncheon dialogue will hold question-and-answer sessions following their presentations (pre-registration required; see registration form).

Approximately thirty 1-½ hour symposia selected from a nationwide call for proposals on topics related to theory, research, practice and policy concerning infants, toddlers and their families, will be offered at sessions on Friday afternoon, December 4 and at morning and afternoon sessions on Saturday, December 5.

A Friday evening poster session/reception and a Sunday morning poster session/continental breakfast will feature presentations, selected from a nationwide call for proposals, describing research findings, service delivery models, public education initiatives, tools for assessment and evaluation, and approaches to parent and professional training.

Informational and clinical/research videos will be shown at several sessions during the 2-½ day institute.

REGISTRATION INFORMATION

Registration is limited. The registration fee of $150 will cover admission to all institute sessions, including the Friday evening poster session/reception and the Sunday morning poster session/continental breakfast.

An early registration fee of $125 is offered to those whose registration for the training institute is received before September 14, 1987. Any cancellation must be made in writing, accompanied by a self-addressed envelope. For cancellations received after November 13, $25 will be deducted from the refund. No refunds will be given for cancellations after November 27 unless individually approved by the Conference Coordinator.

The tenth anniversary celebration reception and dinner will take place Thursday evening, December 3, at 7 p.m. Until September 14, tickets will be available to registered training institute participants for $75.

Pre-institute seminars will take place on Friday morning, December 4 from 9:00 to 11:30 a.m. An additional fee of $25 will be charged. Registration for each seminar is limited, and will be made on a first-come, first-served basis. First, second and third choices should be indicated on the registration form. An institute luncheon will be held on Saturday, December 4. Tickets will cost $20. Participants preferring to have lunch on their own in the neighborhood of the hotel will be provided with seating for the luncheon dialogue.

FACULTY

Mary Ainsworth
Heidelise Als
Gina Barclay-McLaughlin
Kathryn Barnard
Leila Beckwith
Victor Bernstein
Kathleen Kirk Bishop
T. Berry Brazelton
Philippa Campbell
Vicki Carlson
Jude Cassidy
Roseanne Clark
Virginia Demos
Carl Dunst
Carolyn Eichberg
Susan Epperson
Joanna Erikson
Barbara Fields
Nathan Fox
Karen Freel
James Garbarino
Linda Gilkerson
Joy Goldberger
Stanley Greenspan
Robert Harmon
Irving Harris
Penny Hauser-Cram
Margaret Heagerty
Ellen Hock
H. Joseph Horacek
Carollee Howes
Judy Howard
Barbara Ivins
Nancy Kaplan
Daniel Kessler
Gunhild Kestermann
Vicki Kropenske
J. Ronald Lally

Wendy Lazarus
Alicia Lieberman
Marla Mack
Mary Main
Merle McPherson
Samuel Meisels
Edgardo Menvielle
Dolores Norton
Joy Osofsky
Jeree Pawl
Candice Percansky
Judith Pekarsky
Stephen Porges
Florene Poyadue
Sally Provence
Kyle Pruett
Steven Seligman
Rebecca Shahmoon Shanok
Jack Shonkoff
Rosalie Streett
Jule Sugarman
Georgina Sumner
Stephen Suomi
Robin Thomas
Ann Turnbull
Rachelle Tyler
Judith Viorst
Theodore Wachs
Fred Volkmar
Bernice Weissbourd
Nora Wells
Emmy Werner
Donna Weston
Serena Wieder
Patricia Wilbarger
G. Gordon Williamson
Geneva Woodruff
Shirley Zeitlin

REGISTRATION FORM

☐ I wish to register for "Frontiers and Front Lines," NCCIP's Fifth Biennial National Training Institute ($150; $125 until September 14)

$ ______

☐ I wish to attend NCCIP's Tenth Anniversary Celebration Dinner on Thursday evening, December 3 ($75)

$ ______

☐ Please enroll me in the 2-½ hour pre-institute seminar indicated below (give first, second and third choice) ($25)

$ ______

- ____ **A.** Funding opportunities for research and services
- ____ **B.** Concepts in infant mental health (designed for participants with non-mental health backgrounds)
- ____ **C.** Issues in implementing P.L. 99-457, the Education of the Handicapped Act Amendments of 1986
- ____ **D.** Frontiers of attachment research
- ____ **E.** Infants, parents, professionals and AIDS
- ____ **F.** Strategies for parent/professional advocacy for state support services for infants, toddlers and their families
- ____ **G.** Designing and sustaining longitudinal research with infants and families
- ____ **H.** Working with multirisk families: forming partnerships and coping with stress
- ____ **I.** Whose child is it anyway? Supporting young children with chronic illness and their families
- ____ **J.** A family systems approach to early intervention
- ____ **K.** Follow-up of infants exposed prenatally to drugs: a service model
- ____ **L.** Neurobehavioral assessment of preterm infants: implications for care
- ____ **M.** Physiological assessment in infancy
- ____ **N.** Assessing the sensory integration of infants and toddlers: implications for intervention
- ____ **O.** Adaptive coping of infants and toddlers
- ____ **P.** The Infant and Toddler Developmental Assessment (IDA) and the Parent Infant Observation Guide: tools for training professionals and paraprofessionals to assess infants and families.
- ____ **Q.** Clinical diagnosis in infancy: models and current issues (for experienced practitioners and researchers)
- ____ **R.** Introduction to the strategy of assessment of parent-child interaction (NCAST scales)
- ____ **S.** New models for collaborative parent/professional training

☐ I wish to attend the following discussion session (please select one; registration limited, to be filled on first-come, first-served basis). No extra charge

- ☐ **1.** Friday, 3:30-5: Virginia Demos and Emmy Werner
- ☐ **2.** Saturday, 10:15-11:45: Stanley Greenspan and G. Gordon Williamson
- ☐ **3.** Saturday, 2:30-4: Carl Dunst, Florene Poyadue, Gina Barclay-McLaughlin, Judith Viorst

☐ I wish to attend the luncheon on Saturday, December 5 ($20)

$ ______

Total Amount $ ______

Please enclose a stamped, self-addressed envelope with this form.

☐ Enclosed is a check, payable to NCCIP for $ ____________

☐ Charge to ☐ Master Card ☐ Visa

Account # ______________________________

Credit card expiration date ____________________

Signature ______________________________

(required if credit card is used)

☐ I wish to receive a registration card from the J.W. Marriott Hotel (conference rates $85 single or double/night)

☐ I wish to receive a registration card from Washington Plaza-Hotel (Conference rates $70 single, $80 double/night).

If you wish a confirmation of registration, confirmation will be sent for all registrations received by November 23.

Name ______________________________

Address ______________________________

____

City ____________ State ____________ Zip ________

Return to: Eileen Powell
NCCIP, 733 15th Street, N.W., Suite 912
Washington, D.C. 20005
(202) 347-0308

Employer ID # 52-1152319

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developmental tests, a health evaluation, and observation of behavioral and family functioning. Developmental screening is accomplished by administering a developmental inventory, the Gesell Revised Development Screening Inventory for children under three, or the Comprehensive Identification Process [CIP] for those over three and a language test, the Receptive-Expressive Emergent Language Scale [REEL] for those under 3 or the Zimmerman Preschool Language Scale for those over 3. Behavioral observations include details on the child's ability to modulate attention, affect, and impulse control as well as emotional responses to the medical setting and the pattern of interaction with mother. The child's family background, social and medical factors are also considered. All of these areas influence decisions about a child's developmental needs. For example, a child with a history of high lead levels who also has a questionable developmental score, whose play is unfocused and whose family situation is unstable would be referred for services whereas a child with a similar score but with no significant health problems, distractability, or adverse family factors would not automatically be referred. Follow-up data from developmental evaluations completed by program service providers strongly suggest that this approach, basing need for referral upon multiple factors, has been highly accurate. No program has determined any referral by the Project to be inappropiate.

The following case vignette provides an illustration of the work conducted by the Child Development Project.

Marty Roberts, aged 3 years, has been treated medically and followed in the Lead Clinic for nine months due to high levels of lead in his blood. With the initiation of the Child Development Project, Joanne, an educator will conduct a developmental assessment during Marty's next regularly scheduled follow-up appointment. When Mrs. Roberts arrives for this appointment with Marty she has two of her other children with her, Rebecca, age 5 and Will, age 2. The youngest child, aged 4 months, is at home with his grandmother. Joanne will see Marty before he is evaluated by the pediatrician and nurse. To keep the other children busy Joanne gives them paper and crayons prior to asking Marty questions about his trip to the clinic, his clothing, etc. When it becomes clear that he is not responding verbally and is in fact withdrawing, Joanne asks his sister to draw with him. He begins to scribble tentatively on his sister's paper. Joanne is only able to elicit a few poorly articulated words from Marty. Mrs. Robert reports that he says single words to her at home and while other people have difficulty understanding him she does not. During unstructured play he appears distractable and goes from trucks to puppets to stuffed animals, playing with each in an superficial fashion.

Joanne also notices that Rebecca's use of language appears quite immature and asks permission to assess her. Mrs. Roberts reports that Rebecca is in a half day kindergarten program and her teachers have expressed concern about her language. Rebecca's developmental score indicates an overall delay of approximately 4 months, with a language delay of 6 to 8 months. Mrs. Roberts agrees to allow Joanne to contact Rebecca's teacher to get more information about her. Will was also assessed and appears to be functioning at his age level of two years.

Joanne shares her findings at the lead team meeting that day, prompting them to conduct a visit to the Roberts' home. The pediatric nurse discovers all four children and two adults living in a two bedroom apartment which is barely furnished. The children, who were all dressed up for the visit to the clinic, are now observed to be quite poorly and inappropriately dressed for the season.

The information about each child in the family is discussed at the next lead team meeting. It is clear that Marty's development and behavior represent a serious problem which needs immediate attention. Joanne will refer Marty to the preschool special education program of the public school for further evaluation and treatment. Until a treatment program is put in place she will work with Mrs. Roberts and Marty through parent education, modelling and direct interactions with Marty himself. Rebecca's delay, although not severe enough to warrant placement in a special education class, does require special services, and a referral is made to a neighborhood language class to supplement the half day kindergarten experience. the progress of Marty and Rebecca will be monitored by the Child Development Project. The two younger children, while not displaying any significant problems at this point, are clearly at risk. One wonders whether their development and behavior will continue to progress normally given the history of their elder siblings. Their progress will be monitored by the Project and a referral to a parent-child group will be made for Will. Finally, the lead team social worker will look into the family's living conditions and assess the adequacy of Mrs Roberts' social support as well as her mental health status.

Within the context of a routine visit to Lead Clinic, the collaborative efforts [illegible]diatrician, nurses, social workers and educators identified and arranged services for a family whose children either had special needs or were at risk for developing learning problems. Prior to their contact with the Child Development Project, these children had not been identified as needing developmental services and might not have been identified until they began to demonstrate significant problems in school. Through early intervention and monitoring their continuing progress we hope to avoid the possiblity of later school failure and need for costly special education services.

Of the first 773 children seen by the Child Development Project, 254 (33%), were determined to need services. Most of these children were not severely delayed; they typically had a delay of one year or less in one or more developmental areas, primarily language

and cognition. However, these mild to moderate delays were compounded by a medical problem and/or high risk social factors. A small number, however had significant problems.

The most difficult and often frustrating aspect of the Child Development Project's work has been finding services for children who need them. Project staff who conduct a child's assessment also serve as that child's case coordinator, working with the family to ensure that appropriate intervention services are provided. Referrals are made to programs that can provide services in the least restrictive environment: day care, family day care, specialized family day care, Head Start, parent-child programs. Although Massachusetts is a leader in the field of early intervention services for children under three years of age, waiting lines for programs in the greater Boston area range from two to six months. This is especially true for children identified as having a problem when they are approximately 2½ years old. These children tend to fall through the cracks between Early Intervention (birth to 3 years) and Preschool Special Education (3-5 years). Further barriers to the timely provision of services are a complicated system of geographically coded referral sites, an overworked school staff who cannot optimally support parents because of the demands of an enormous load of paperwork and regulations, and a scarcity of programs for children with mild or insidious developmental disturbances.

Thus, one of the Project's most important functions has become advocacy for provision of appropriate services. The dilemma of assessing children and being unable to provide them with services is all too familiar; it must be tackled by an aggressive advocacy through such diverse channels as local and state Departments of Health and Education. The Child Development Project devotes large amounts of time and energy to forging alliances between these agencies.

Project Prime, a joint effort of the Child Development Project, Wheelock College, and the Boston School Department, is another collaboration between physicians and educators. Funded by the Boston School Department through a grant from the State Department of Education and the Deborah Munroe Noonan Memorial Trust, Project Prime is a community-based model program of health and educational services for children referred primarily by the Child Development Project with mild to moderate language and/or special social delays and their parents. The program addresses children's developmental delays within the context of parent-child interactions in a family-focused intervention model featuring home visits as well as a health component. Small groups of mothers and their children meet bi-weekly with an early childhood specialist in a preschool classroom setting, participating in planned and informal play activities. Additionally, each group of mothers meets weekly with a parent educator and pediatrician to share information and experiences, forming a support system for each outside the context of the Project.

In the delivery of services to young children with special needs and their families a medical-educational collaborative model has several advantages. Besides supplying medical findings relevant to a specific child's developmental profile, physicians provide background medical information to early intervention and preschool special needs staff through inservice. Although primarily a service delivery model for young children, the Child Development Project is also a training site for early childhood educators and pediatricians. The Wheelock College Graduate School offers training in early intervention, preschool special education and child life. The program includes supervision in clinical settings, a course titled Medical Aspects of Disabling Conditions in Young Children, taught by pediatricians, other courses involving family systems as well as the dynamics of parent-professional relationships, and an elective seminar either in biomedical ethics or research in early intervention. Thus, students chosen for practicum placements at the Child Development Project are well-equipped to assess infants and young children in a medical setting using a family-focused approach. The project serves as a hands-on training site for early childhood educators to collaborate and share knowledge with pediatricians and medical staff.

The educators of the Child Development Project staff also contribute to the education of pediatricians, medical students and nurses through seminars, clinical supervision and as collaborators in clinical settings. Medical students and pediatric residents learn about normal child development and daycare through the Day Care Program, which involves participation in a neighborhood daycare center followed by a seminar discussing observations of children's behavior, teacher-children interactions and the social-political issues of daycare. In clinical settings, through formal structured experiences or as clinical collaborators, educators teach pediatricians and nurses techniques for formal and informal developmental evaluation and demonstrate strategies for placing children in appropriate intervention programs.

Conclusion

Another education outcome of this medical-educational collaboration was a conference entitled, *Young Children with Special Needs: New Challenges for Parents and Professionals*. Co-sponsored by the Project, Wheelock College and the Federation for Children with Special Needs, a family advocacy organization, the conference clarified the necessity of physician-educator collaboration and parent-professional relationships.

The health and developmental needs of young children living in poverty cannot be treated as separate issues, each addressed by a separate discipline. These children are best served by a collaboration of medical and educational specialists who can identify insidious developmental problems and ensure the provision of timely and appropriate services. Pediatricians and early childhood educators have a great deal to offer each other and a tremendous amount of support to give to young children and their families.

National Center Notes

by Eleanor S. Szanton

The National Center for Clinical Infant Programs will publish three documents this month that we hope will be useful to people working to promote the healthy development of infants, toddlers and their families.

The first two publications were developed by NCCIP's Program Evaluation Task Force, with support from the A.L. Mailman Foundation, in response to the need of service providers and their funders for guidance in evaluating programs that serve young children and families.

Charting Change in Infants, Families and Services is addressed to practitioners and administrators. It suggests that all programs serving young children and families can and should engage in evaluation. It discusses and illustrates steps that service providers can take, even with severely limited time and resources, to devise evaluation strategies that reflect the actual work of the program and that are likely to provide information needed for program improvement.

Evaluating Service Programs for Infants, Toddlers and Their Families: A Guide for Policymakers and Funders, reviews and illustrates more briefly the kinds of evaluation efforts funders and policymakers may reasonably expect from service providers. It also suggests steps that funders themselves can take: 1) to encourage meaningful evaluation initiatives and 2) to foster the use of evaluation findings to enhance the healthy development of young children and the well-being of their families. Those who wish to receive one or both publications should use the order form that is part of this issue.

The third publication, produced with support from the Ford Foundation, inaugurates a new National Center series of policy-relevant research reports. C. Arden Miller's report, **Maternal Health and Infant Survival** is an analysis of medical and social services to pregnant women, newborns and their families in ten European countries, with implications for policy and practice in the United States. Dr. Miller, Professor and Chairman of the Department of Maternal and Child Health at the School of Public Health, University of North Carolina, Chapel Hill, undertook to examine practices in European countries with infant mortality rates lower than those in the United States.

"Patterns of perinatal care vary greatly from one country to another except in one important respect," reports Miller. "No pregnant woman in Europe needs to ask how or where she will receive care or who will pay for it. In all of the countries studied, various options for care are available, but that variation does not obscure access to well defined provider systems that are universally available, well known, and with no self-pay barriers. In all countries the entire sequence of perinatal care is either free without means testing or involves negligible charges that are readily waived in the event of need." Dr. Miller shows that even countries with pluralistic forms of health care coverage, with sizeable immigrant and minority populations, or with lower per capita income than the United States provide these services. *Maternal Health and Infant Survival* describes medical and social service strategies which, if implemented, would be likely to lead to reduced rates of infant mortality and low birth weight in the United States, and would ultimately reduce public health care expenditures. To obtain copies, use the publications order form in this issue.

The selection of National Center Fellows for 1987-88 gives us a fine group for the next academic year. Each is listed below, along with his or her discipline and affiliation. Second-year Fellows are indicated with an *.

- **Robert Adair, M.D.,** Pediatrics, Boston University, Boston City Hospital
- ***Helen K. Buchsbaum, Ph.D.,** Clinical Psychology, University of Colorado
- ***Vicki K. Carlson, Ph.D.,** Psychology and Epidemiology, Washington University
- **Michelle Gersten, Ph.D.,** Developmental and Clinical Psychology, Yale Child Study Center
- ***Jeanne T. Grace, R.N.** Nursing, University of Rochester
- ***Nancy W. Hall, B.S.** Developmental Psychology, Yale Department of Psychology
- **Marla Hooks, M.D.** Psychiatry and Pediatrics, Yale Child Study Center
- ***David Howell, M.D.** Pediatrics, Boston University, Boston City Hospital
- **Stanley Ip, M.D.** Pediatrics, Harvard Child Development Unit
- **Mark David Israel, M.D.** Pediatrics, Michigan State University
- **Teresa Kohlenberg, M.D.** Pediatrics, University of Massachusetts Medical School-Worcester
- **Lorraine Kubicek, M.A.** Behavioral Sciences, University of Chicago Behavioral Sciences
- **Gilda Morelli, Ph.D.** Developmental Psychology, University of Utah
- ***Michael G. Regalado, M.D.** Pediatrics, UCLA Medical Center
- ***Donna Weston, Ph.D.** Developmental Psychology, University of California, San Francisco

Finally, the National Center for Clinical Infant Programs takes great pleasure in announcing the election of **T. Berry Brazelton** as its President-Elect. His presidential duties will begin in the spring of 1988, upon the completion of the term of **Sally Provence,** our current President. Dr. Brazelton was a founding member of the National Center and has served as Co-Chair of its Fellowship Committee, Chair of its Institutes Committee, Chair of the Tenth Anniversary Celebration Committee, and Vice-President.

Clarifications of and updates to selected statistics in NCCIP's publication *Infants Can't Wait: The Numbers* may be obtained by writing to the National Center office.

Infant Day Care Responses, continued

The September, 1986 issue of *Zero to Three*, which focused on aspects of child care for infants and toddlers, occasioned a number of responses from our readers. These were published in the February, 1987 issue of *Zero to Three*. In recent months, child care for infants and toddlers has been the subject of many articles in the popular press and of reportage on national television. Two additional sets of comments have also been submitted to *Zero to Three*, and appear below.

Two Principles to Govern Judgment

JOHN A. DAVIS, *University of Cambridge Clinical School, Department of Paediatrics*

May a reader from the other side of the Atlantic offer some comments on the debate in your columns between Dr. J. Belsky and Deborah Phillips on the supposed advantages or disadvantages of day-care programmes for young infants. What I would like to state are two principles that in my view should govern our judgement in such matters: the first, that the onus of proof rests on those who maintain that it is desirable (or not desirable) to depart from traditional patterns of child rearing especially early on: the second, that those whose arguments live by the manipulations of statistics must be prepared to let them die by it.

Now that Rutter's statistical approach to child psychiatry has moved from fashionable acceptance to scientific respectability with his election to the Royal Society, I realise that I am in a small minority in quoting D.W. Winnicott's diatribe against this method of studying human nature and child development.

"Those who have spent their life doing psychoanalysis must scream out for sanity—against the insane belief in surface phenomena that characterises computerised investigation of human beings." D.W. Winnicott.

But I do feel very strongly that we should not subject our babies to unnatural styles of care on the basis of large-scale short duration experiments open to very different interpretations according to the philosophical bias of a particular worker or group of workers in the interest of maintaining a socio-economic system whose ostensible values may not reflect the needs and aspirations of ordinary decent parents. No one these days has to cumber themselves with children; but if they do, what they should be aiming for is grown-ups capable of love and work, as Freud put it. Our aim should not be the rearing of a compliant generation but one capable of dealing with the horrendous problems that we have generated for ourselves over the past century and which reflect the alienation in so many people from the society in which they find themselves. So two cheers for J. Belsky and none at all for his opponents from this beleaguered outpost of civilised values threatened not by barbarian invasion but by "le trahison des clercs."

Some Further Comments About Infant Day-Care Research

PETER BARGLOW, M.D., *Michael Reese Hospital and Medical Center and The University of Chicago*

In the September, 1986 and February, 1987 issues of *Zero to Three*, the subject of day-care for infants under one year of age was discussed extensively and heatedly. Using Belsky's citation of the soon-to-be-published work of myself and my colleagues as my ticket of admission, I want to join the debate to ask if we cannot generate more light and less heat when we discuss this topic. I am quite worried about the effect of the recent national publicity generated by our debates, presentations and publications. When members of our child development academic community split into factions with leaders that attack Belsky's ideas in public statements such as, "I think it's bunkum." In the pages of the *Wall Street Journal* (Ricks, 1987), the public—always fascinated by internecine squabbles—will suspect that all of our carefully derived findings are ridiculous or meaningless. Without delving into the complex subject of how much of our science is affected by presuppositions and bias, what, for example is the casual reader to think of the objectivity of a researcher who defiantly dedicates her pro day-care book to her child who "spent his first year in day-care so that this book could be written" (Clark-Stewart, 1982)? When a distinguished developmental scientist joins the fray by summarizing her view of the Ainsworth Strange Situation by quoting Rutter's (1981) single, offhanded comment, questioning it as a "curious procedure...obscure to the child" (Chess, 1987), thousands of meticulous observations can go up in smoke—and I

Barbara Young

have a potential problem in following and recruiting research subjects. For instance, one of our project participants who mistakingly concluded her baby was "insecurely attached," and therefore "damaged" on the basis of a criticism of our study in *Glamor Magazine*, promptly dropped out of our follow-up program.

Complex ethical questions that urgently need to be addressed are obscured or left concealed by such public arguments. Do I have an obligation to tell a mother that her baby is insecurely attached, or at risk for heightened preschool aggressiveness? If so, this feedback will obviously unpredictably influence the psychosocial and developmental data subsequently obtained. Will I even get her cooperation for further studies? How can we best preserve the fragile observer/study-subject alliance crucial to our work? What is to compensate our subjects for the many hours they spend in filling out tedious (to them) questionnaires and subjecting themselves to long hours of observation? Our program offers free future years' developmental consultation to parents whose research infants or their siblings have later emotional difficulties. (When this service is utilized, the subjects' data must be eliminated from further study assessment.) Goldberg (1979) has started to evaluate these crucial questions with respect to longitudinal infant studies.

What can be done to confront the issues in a more propitious atmosphere? I think we should avoid global statements about risk. The remark, "Belsky's admonition that infant care—apparently any non-maternal infant care—exposes infants to risk..." (Phillips et al., 1987, p. 18), raises the red flag of battle for parents, feminists and researchers alike, stimulating visions of battered, abused babies, premature low birth weight infants or offspring of substance abusing mothers. We need not only to specify—at risk *for what* (?) but to carefully limit the notion of what is implied by the idea of "risk factor." To say that infants in day care are "at risk" implies a concept of a one-to-one correlation, a cause and effect relationship that has no place in the quantitative statistical studies that characterize developmentalists' work. The idea that a certain specific outcome is due to a single variable doesn't even apply in the realm of the strictly biological and physiological. Thoman and Becker (1979) have pointed out that the use of a single, independent variable is invalid even for neurophysiological infant assessment and prediction. Even the seemingly straightforward relationship between the ingestion of a drug and its physiological effect is complicated by such closely linked variables as the quantity of the drug administered, the mode of administration, the time of administration, and interaction with other drugs (Kraemer et al., 1972). It is even more unlikely that a single variable, such as day-care, can ever be shown to have a one-to-one correlation with any outcome. To discern the effects of day-care requires considerably more complex methods than does the determination of the physiological effects of a drug. Studies regarding "risk factors" for specific developmental outcomes are more like investigations that determine if smoking is a risk factor for the development of lung cancer. Results are provided in terms of statistical correlations and a hierarchy of contributants and host factors, not as single cause-effect relations.

The issue of infant vulnerability in general is another important one not usually addressed by heated debates on whether or not day-care puts infants psychologically "at risk." Factors relevant to vulnerability, such as family stress, age at entry to day-care, quality of care, the infant's gender and physical health status, maternal attitudes toward parenting and toward work, familial, ethnic and cultural identity, the soundness of the parental marriage, and the mother's separation anxiety, may be crucial. Nor should we overlook infant resilience factors, such as those eloquently described in the Kauia Longitudinal Study (Werner and Smith, 1982). Resilient children exposed to chronic, severe poverty, multiple perinatal risk factors, and stress life events could use "ameliorative factors in themselves and in their caretaking environment" (p. 133) on the path toward a successful developmental outcome. This does not mean, however, that "chronic poverty" or "multiple perinatal stresses," for example, are not "risk factors" for the development of certain developmental problems.

Can these interacting variables be teased apart? We hope the answer is yes, but the process requires more carefully controlled and larger studies rather than further heated arguments based on ideology from either side. Our own findings (Barglow, Vaughn & Molitor, 1987) regarding the effect of full-time working mothers on infant attachment were, in effect, serendipitous—we did not start out studying the matter of day care at all, but began as an attempt to study the association of maternal endorphin levels in pregnancy with pain perception during labor. Because of the special characteristics of our sample we were able to control for several confounding factors, such as low SES, high familial stress, and the effects of group day-care. Our research assessed 110 infants of affluent, mostly upper-middle class parents, half of whom were cared for full-time by the mother, and half of whom had in-home day-care provided by someone other than the mother because both parents had full-time paid work commitments: (the mother was out of the home because of work for a mean of 30 hours per week).

We unexpectedly found an increased incidence of avoidant attachment among first-born infants of the working mothers. We could not relate this finding to maternal demographic, attitudinal, or personality characteristics, or maternal judgments about offspring temperament, behavior, or developmental milestones as measured by a battery of accepted psychological assessment instruments. In a subsequent effort we obtained preliminary data using Hock's (DeMeis et al., 1986) scale, which suggested that maternal separation anxiety related to the mother's leaving her infant in someone else's care distinguished between securely and insecurely attached infants of full-time working mothers, although in a counter-intuitive way, high maternal separation anxiety was related to secure attachment (Barglow, Cory & Maloney, 1987). Gender may also exert a significant influence (Vaughn, 1987).

Obviously, we need to identify other covariates related to the mother's working outside the home. We should, for example, evaluate the effects of the quality of all kinds of infant care, not just day-care. Such studies should include evaluation of alternative care-giving persons and the prolonged effect of other-than-mother secondary caregivers in the home as well as in group settings (Brazelton, 1986). Do the infants form secure attachments to their secondary caregivers? What is the effect of disruptions in that relationship? Possibly, infants with strong emotional bonds to care providers other than the parents have a different developmental pathway following the Strange Situation than that considered typical for children exclusively reared by family members (Vaughn et al., 1985, pp. 115-116).

In our just-completed study, we obtained an overall impression that the alternative home care providers offered a stable emotional environment for children in the home, but we could not quantify this influence. Inquiry into this subject was hampered by the fact that our working subjects were not enthusiastic about inquiry directed toward their offspring's relationship with the secondary caregiver, probably because of a fear that they might have lost the position of primary love object for their children.

A relevant, recent psychoanalytic article reported "estrangement from biological mothers and intolerance of intimate relationships in analytic patients with an early history of primary surrogate mothering" (Hardin, 1985, p. 628). The generalizability of these findings is limited by the use of retrospective reviews of the patients' early life events, rather than by prospective information gathering with a defined data base. But case histories of individual children can yield valuable clues informing us "how the infant actually functions in the real world" (Thoman and Becker, 1979, p. 466). But all the preceding questions become harder to answer in a super-charged atmosphere of confrontation. Angry charges and countercharges will not help any of us to recruit new subjects that have the random distribution that we need for statistically valid studies. Further ideological polarization will make the public consider *all* our research "bunkum" if that is how we describe one another's work, instead of carefully assessing its validity according to established scientific criteria.

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Infants Can't Wait, 1986 $5.00/set, plus $1.50 postage and handling
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and

Infants Can't Wait: The Numbers, 1986
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Evaluating Service Programs for Infants, Toddlers and Their Families: A Guide for Policy Makers and Funders, 1987 $1.50/copy. Bulk rate available.
Reviews and illustrates the kinds of evaluation efforts funders and policy makers may expect from service providers. It also suggests steps that funders can take to encourage meaningful evaluation initiatives and to foster the use of findings to enhance the physical and emotional health of young children and their families.

Charting Change in Infants, Families and Services: A Guide to Program Evaluation for Administrators and Practitioners, 1987 $4/copy. Bulk rate available.
Suggests that all programs serving young children and families can and should engage in evaluation, and discusses steps that service providers can take to devise evaluation strategies which reflect actual program work and which will provide information needed for program improvement.

Maternal Health and Infant Survival: An Analysis of Medical and Social Services to Pregnant Women, Newborns and Their Families in Ten European Countries, with Implications for Policy and Practice in the United States, C. Arden Miller, M.D., 1987 $6.00/copy. Bulk rate available.
Analyzes health care and social supports for pregnant women and their families in ten western European countries with infant mortality rates lower than those in the United States. Analysis, which has major implications for U.S. health policy, reveals a set of strategies which, if implemented, could lead to reduced rates of infant mortality and low birth weight in the United States, and would ultimately reduce public health care expenditures.

Finding the Best Care for Your Infant or Toddler, Laura L. Dittmann, 1985 No charge for single copies
Provides parents with information on elements of good care for infants and toddlers, and answers common questions about choosing care. A brochure published jointly by the National Center for Clinical Infant Programs and the National Association for the Education of Young Children.

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Psychopathology and Adaptation in Infancy and Early Childhood: Principles of Clinical Diagnosis and Preventive Intervention, Report No. 1, Stanley I. Greenspan, M.D., 1981 **$27.50**

Presents and illustrates Greenspan's developmental structuralist approach to the classification of adaptive and pathological personality organizations and behaviors in infancy and early childhood, and discusses the implications of such an approach.

Infants and Parents: Clinical Case Reports, Report No. 2, Sally Provence, M.D., ed., 1983 **$32.50**

Presents detailed case studies illustrating diagnostic and therapeutic issues and methods relating to infant mental health. T. Berry Brazelton, Kyle Pruett, Jeree Pawl and Judith Pekarsky, Alicia Lieberman and Peter Neubauer are among the authors of seven case reports that describe in rich detail how clinicians from a variety of settings use a range of therapeutic approaches to help children and parents in the first years of life.

Infants in Multirisk Families: Case Studies in Preventive Intervention, Report No. 3, Stanley I. Greenspan, M.D., ed., 1987 **$40.00**

Presents four detailed case studies of infants in multirisk families, which provide clinical data for the relatively new field of comprehensive clinical preventive approaches for infants and their families. Conceptual chapters look for patterns and principles in the clinical experience, present criteria for comprehensive developmental diagnosis for infants and very young children, and outline operational criteria for the progression of the therapeutic process itself.

The following publications are available, free of charge, from: The National Maternal and Child Health Clearinghouse, 38th and R Streets, N.W., Washington, D.C. 20057, (202) 625-8410

Project Zero to Three Publications

Under a grant from the Division of Maternal and Child Health, U.S. Department of Health and Human Services, Project Zero to Three aims to have a national impact on improving services to children from birth to three years of age who are disabled or at risk of handicap. Project Zero to Three began in 1983 and is funded through mid-1988. The following publications, developed under the project, are available free of charge.

There Ought to Be a Law? Ensuring State-Wide Services for Disabled and At-Risk Infants and Toddlers, 1985

Outlines the policy options available for establishing or expanding state services for disabled and at-risk infants, factors to consider when undertaking such efforts, and pitfalls to avoid both during the planning process and in the context of the legislation itself.

Keeping Track: Tracking Systems for High-Risk Infants and Young Children, 1985

Discusses realistic goals, instruments, and techniques; criteria for inclusion and discharge; agency or group responsibility; the role of parents; and the limitations imposed by funding restrictions. Includes materials from the tracking systems of Iowa, Maryland, North Carolina, Texas, Utah and Washington.

Equals in This Partnership: Parents of Disabled and At-Risk Infants and Toddlers Speak to Professionals, 1985

Parents share ideas and insights into the joys and difficulties of raising children with special needs, including their experiences with the medical profession and other service providers.

Program Evaluation: Issues, Strategies and Models, 1986

Presents and discusses themes raised in a July, 1984, meeting of administrators, researchers, and clinicians on issues, strategies, and models of evaluating services for disabled and at-risk young children and their families.

Warning Signals: Basic Criteria for Tracking At-Risk Infants and Toddlers, James Blackman, M.D., 1986

Outlines a basic set of criteria useful in selecting infants and toddlers for inclusion in tracking systems designed to follow children at risk for impaired development.

Early Intervention: Concerns of a Career in Nursing: Proceedings of a Symposium in Honor of Camille L. Cook., R.N., M.S.W., 1986

Speakers addressed the distinct role which the nursing profession plays in primary prevention of disorders in infants and young children, in intervention, and in case finding through screening and assessment. They noted problem areas, as well as successes, in the planning and implementation of early intervention programs.

Report Accompanying the Education of the Handicapped Act Amendments (Report #99-860) and Commenting on P.L. 99-457, Linda Gilkerson, Asa Grant Hilliard, III, Emily Schrag, and Jack P. Shonkoff, 1987

Duplicates the Congressional Report, which is no longer available from Congress. The Report contains a summary of the Act, the need for and intent of the law, cost estimates, and the language of the law itself. Comments attempt to place P.L. 99-457 in the broader context of current national initiatives on behalf of very young children and their families.

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Publications

Handbook of Infant Development, Second Edition—Joy Doniger Osofsky, editor (New York: John Wiley & Sons, Inc., 1987) $69.95.

This 1391-page volume, with 43 contributors from the United States and abroad, is designed as a resource volume for researchers in the field of infancy and "as a place to begin for serious students." The presentation of normal development in infancy includes chapters on visual and auditory development, learning and memory, language and communication, cognitive development, psychophysiological development, cross-modal abilities and developmental behavioral genetics. Social and emotional growth are viewed from a range of conceptual perspectives. Issues of assessment, methodology and analysis are addressed. The growth of research in prevention, clinical and applied areas is reflected in increased emphasis, in this edition of the handbook, in areas of developmental risk, clinical approaches and intervention.

The section on current issues and perspectives identifies new directions, areas of controversy and points of integration within the field of infancy. Inge Bretherton reviews attachment theory and research and places the work in a broader psychoanalytic framework. Jack Bates discusses temperament in infancy. Jerome Kagan focuses on perceptual, cognitive and emotional competencies that seem to be "biologically prepared." Robert McCall examines changing relationships among the media, society and child development research. Michael Rutter conceptualizes an interactional process between the organism and experience as a way of understanding continuities and discontunuities in development. Robert Emde reviews progress and current dilemmas in the interdisciplinary field of infant mental health, including issues of diagnosis, prognosis, perspectives on "normality," social values and intervention opportunities.

In Support of Families—Michael W. Yogman and T. Berry Brezelton, editors (Cambridge, Massachusetts: Harvard University Press, 1986) $25.00.

Michael Yogman, T. Berry Brazelton and the other contributors to this volume find that viewing the family as a system, interacting with other systems, enables us to better understand the influence of stresses and supports on child development. One can use systems theory as a framework for the question, "What do individual families need in order to provide their children with the supportive backgrounds needed to master the stresses of daily living?"

The fourteen chapters in the book address this question and focus on: 1) the theoretical framework for discussing the family as a system; 2) the impact, positive and/or negative, of stress on the family's effectiveness in raising children; and 3) the environmental context, including support systems of friends, extended family, employment, child care, schools and health. Contributors to the volume include David Reiss, Jerome Kagan, Felton Earls, Ross D. Parke, Richard N. Atkins, Ann C. Crouter, Maureen Perry-Jenkins, Ellen Galinsky, Abraham Zaleznik, Gwen G. Morgan, Kathleen A. Camara, John M. Leventhal, Barbara F. Sabbeth, Lorraine V. Klerman, Bettye M. Caldwell, Lisbeth B. Schorr, C. Arden Miller and Amy Fine.

U.S. Children and Their Families: Current Conditions and Recent Trends, 1987—Select Committee on Children, Youth and Families, U.S. House of Representatives (available from the Select Committee, 385 House Office Building Annex 2, Washington, D.C. 20515).

This report updates and expands the Select Committee's initial 1983 study of the same name. It represents a statistical summary of the most recent national data on population, family environment, income, education, health and health-related behavior and selected government programs affecting children.

Since data for various years are presented, trends can be noted. For example, as of 1986 half of all married mothers with children one year old or under were working or looking for work. In 1975, the comparable proportion was 31 percent, and in 1970, only 24 percent. The report documents that progress in reducing infant mortality has slowed dramatically. Black infants continue to die at nearly twice the rate of white infants, and the gap has widened over the past five years. In 1980, the white infant mortality rate was 10.5/1000 live births; the black rate, 21.4/1000. In 1984, the white rate was 9.4, the black, 18.4.

Growing Points of Attachment Theory and Research—Inge Bretherton and Everett Waters, editors, Monographs of the Society for Research in Child Development, Serial No. 209, Vol. 50, Nos. 1-2, 1985. (Available from Child Development Publications, The University of Chicago Press, P.O. Box 37005, Chicago, Illinois 60637) $14.50.

The twelve chapters of this monograph provide an overview of attachment theory and present theoretical and methodological tools for use in further research, as attachment theory is applied to investigations across the life span, across generations and across cultures. In the section of the monograph devoted to theory and assessment, Mary Main, Nancy Kaplan and Judy Cassidy examine not only individual differences in patterns of nonverbal behavior but also look at patterns of language and structures of mind as clues to attachment in infants and older children. Six chapters in the section on adaptation, maladaptation and intergenerational transmission present research on the impact of out-of-home care on child-mother attachment quality and on attachment among maltreated infants, among other topics. Three chapters make up the section devoted to cross-national research on attachment in infancy. North German, Israeli and Japanese investigations are reported.

Back to Basics: Improving the Health of California's Next Generation—Wendy Lazarus with Kathleen M. West (Southern California Child Health Network, 712 Wilshire Boulevard, Suite 1, Santa Monica, CA 90401, 1987) $12.50

Back to Basics is a report of an 18-month study by the Children's Research Institute of California and the Southern California Child Health Network, designed to learn what obstacles pregnant women face in obtaining health services and what might improve the situation. Nearly half a million babies were born in California in 1985, representing one out of every eight babies born in the United States. Data from the study revealed that the number and percent of California mothers who receive late prenatal care or none at all is on the rise, at the same time that high risk pregnancies are increasing. One in 14 babies in California is born to a mother who receives late or no prenatal care. Compared to babies whose mothers received adequate health care, those with no prenatal care are 5 times more likely to die in the first year of life. Infant death rates have recently increased for black babies in California. Nearly all counties studied reported access to maternity care as worsening: because increases in obstetrics malpractice premiums are driving out health providers who offer maternity care, even women with health insurance are facing access problems.

The *Back to Basics* report suggests strategies for making maternity services available in every community, making the price of maternity care affordable, and getting more pregnant women into health care early.

Babies and Their Mothers—D.W. Winnicott, edited by Clare Winnicott, Ray Sheperd and Madeline Davis (Reading, Massachusetts: Addison-Wesley Publishing Company, 1987) $14.95.

British psychiatrist and psychoanalyst D.W. Winnicott (1896-1971) was the author of the famous phrases, "the ordinary devoted mother" and "good-enough mothering" and of the statement, "A baby alone does not exist." This volume consists of nine essays based on talks that Dr. Winnicott originally delivered during the 1950s and '60s to pediatricians, nurses, midwives, nursery school teachers and parents. They deal with the psychological processes that take place in the infant around the time of birth and shortly thereafter, addressing such issues as the minimum needs of every baby, the earliest signs of personality, and communication between infant and mother.

Concerned that his emphasis of the importance of the "ordinary devoted mother factor" in early development might be used by some to blame mothers for children's developmental difficulties, Winnicott states: "We must be able to apportion aetiological significance (not blame)...(because) in no other way can we recognize the positive value of the ordinary devoted mother factor—the vital necessity for every baby that someone should facilitate the earliest stages of the processes of...the growth of the most immature and absolutely dependent human personality."

Born Dancing: How Intuitive Parents Understand Their Baby's Unspoken Language and Natural Rhythms—Evelyn B. Thoman and Sue Browder (New York: Harper & Row, 1987) $15.95.

This book is addressed to parents and is based on Evelyin Thoman's more than twenty years of infant development research, as well as her experience in raising her own six children. Thoman wishes to give parents a sense that a baby "isn't a moldable imperfect creature you have to change, control and improve, but a total, complete, viable person with his own likes and dislikes, who deserves to be trusted, respected and understood."

As the title suggests, Thoman uses dance as a metaphor for interaction between infants and parents. She emphasizes the importance of rhythms in relationships and communication, as well as in eating, sleeping and waking, and other biological patterns. She describes for parents the components of infants' language—gaze, head behaviors, other gestures, and crying. Thoman offers six tactics for comforting a crying baby and twenty-eight techniques (documented with a table from *Child Development*) for making a baby laugh.

School-Age Pregnancy and Parenthood: Biosocial Dimensions—Jane B. Lancaster and Beatrix A. Hamburg, editors (Hawthorne, New York: Aldine de Gruyter, 1986) $39.95.

This volume is the first of a series of volumes sponsored by the Social Science Research Council Committee on Biosocial Perspectives on Parent Behavior and Offspring Development. The biosocial perspective recognizes the continuous, mutual and inseparable interaction between biology and social behavior; this perspective pinpoints areas in which contemporary human parental behavior exhibits continuities with, and departures from, patterns evident throughout human history. Speaking from this perspective, 32 scientists from the disciplines of anthropology, sociology, history, psychiatry, developmental psychology, social work, pediatrics, primatology, human evolution, and public health have contributed chapters to this volume on school-age pregnancy and parenthood.

The editors note that in contemporary industrial societies, both biological and cultural factors have interacted to establish the widest separation between *biological* maturation and *social* maturation known in human history. While a large pool of reproductively mature adolescents are living in a climate of sexual permissiveness, society has minimized social and economic supports for adolescent parenthood, leaving both early adolescent mothers and fathers at very high risk.

The nineteen chapters of this volume address aspects of the life cycle and biological development; emotional, cognitive and social development in adolescence;

comparisons among species, cultures and historical periods; and contemporary issues, including the economic impact of school-age child rearing.

Infant and Childhood Depression: Developmental Factors—Paul Trad (New York; Wiley Interscience, 1987) $45.00.

Paul Trad, the author of this volume, states as his central premise that the multidimensional approach offered by a developmental perspective is mandatory for understanding how depression can evolve in infants and young children. He suggests that depression in early life is a function of the dynamic interplay between variables of temperament, attachment and self-concept evolution, within the more general process of regulation. *Dysregulation* is seen as a potential signal that the infant may develop full-fledged depressive symptomatology if the dysregulation is not remedied.

Five sets of risk factors for infant and childhood depression are identified and discussed: social support, parental psychopathology, abuse and neglect, sickness and hospitalization, and handicapping conditions. In discussing a developmental approach to therapeutic intervention, the author notes that developmental psychopathology does not offer a single, uniform approach to treatment but strives "to tailor a therapeutic program to each infant's or child's specific psychopathology, in the context of his or her overall phase of development."

Maternal Depression and Infant Disturbance (New Directions for Child Development, Number 34, Winter 1986)—Edward Z. Tronick and Tiffany Field, editors (San Francisco, California: Jossey-Bass, 1986) $12.95.

Evidence has accumulated, report the editors of this volume, that maternal depression is related to affective and cognitive disturbance in infants. They note that the exact nature of this relationship is not yet understood and that the models, research methodology and results of the investigators contributing to the volume suggest directions for future research.

Edward Z. Tronick and Andrew F. Gianino, Jr., report on the transmission of maternal disturbance to the infant. William T. Garrison and Felton J. Earls review the epidemiology of maternal depression and infant disturbance. Jeffrey F. Cohn and colleagues examine face-to-face interactions as a vehicle for transmission of disorders from parent to infant. Tiffany Field suggests that maternal deprivation may predispose the infant to *chronic* depression, while effects of early separations from the mother may provide a model for *reactive* depression. Karlen Lyons-Ruth and colleagues present data on environment, interaction, attachment and infant development from a study of depressed mothers and their one-year-old infants.

Child Care: Facing the Hard Choices—Alfred J. Kahn and Sheila B. Kamerman (Dover, Massachusetts: Auburn House Publishing Company, 1987) $26.00.

Authors Alfred Kahn and Shelia Kamerman describe the intended audience for their newest book as "those public officials, interested citizens, advocates and academics who frame the policy debate and engage the choices." Examining the effects of policies launched by the Reagan administration in 1981, the authors note: 1) a decline in subsidized center places for low-income children; 2) the disappearance of a federal child care presence; 3) deregulation of child care at all levels; and 4) a series of contradictory effects (including some creative local responses to unmet needs) resulting from the Administration's policy of privatization.

The authors see states and local communities as the present arena for policy and planning in the child care field but argue that state capacity for policy development, leadership and administration can grow only if the process is given federal support and backing. Kahn and Kamerman suggest that a new child development institution can emerge, anchored in the schools, to offer services to most 2-½ to 5 year olds. Then family day care-center care systems for infants and toddlers might slowly evolve into a more adequate delivery system, anchored in information and referral services and supported by parent fees (with tax help) and public subsidy for low-income families. Paid, job-protected disability and parenting leaves to cover at least 4 months at the time of childbirth or adoption are seen as an essential component of an infant care policy.

Health in Day Care: A Manual for Professionals—Committee on Early Childhood, Adoption and Dependent Care, American Academy of Pediatrics (American Academy of Pediatrics, P.O. Box 927, 141 Northwest Point Boulevard, Elk Grove Village, Illinois 60009, 1987) Single copy, $25.00; quantity prices on request.

This manual, supported in part by the Division of Maternal and Child Health and The Administration for Children, Youth and Families, is addressed primarily to physicians; the editor suggests that individuals not trained in health care but who are responsible for health related aspects of child care programs may also find the volume helpful.

The manual offers the physician information about the world of day care in chapters discussing the promotion of development in out-of-home child care settings, health maintenance in day care, day care for the child with special needs, and day care and child abuse. Additional chapters discuss prevention, control and management of infections and injuries in day care; health training for child care staff; day care regulations; and the health professional as a consultant to day care programs. Appendices include sample child health forms, checklists for parents, and child day care terms.

Health of Children in Day Care: Public Health Profiles—Patricia T. Schloesser, Project Director, (Kansas Department of Health and Environment, 1986) available from Geraldine Funke, Infant and Early Childhood Health Programs, DMCH, BHCDA, DHHS, Parklawn Building, Room 6-37, 5600 Fishers Lane, Rockville, MD 20857.

This publication, supported by the Division of

Maternal and Child Health and the Head Start Bureau, Administration for Children, Youth and Families presents profiles of thirteen state and local public health agency programs designed to safeguard and promote the health and well-being of children in day care. Some of the programs featured provide direct public health services for children, parents and providers; others are more involved in community organization; others have a regulatory role. The publication points out that a legal base for involvement with day care, either as the state licensing authority or through local public health codes, seems to encourage public health agencies to expand *non-regulatory* health promotion and preventive services to the day care population.

A Little Bit Under the Weather: A Look at Care for Mildly Ill Children—Beth Fredericks, Robin Hardman, Gwen Morgan and Fran Rodgers (Boston, Massachusetts: Work/Family Directions, Inc., 1986) Available for $19 prepaid plus $1 postage from Work/Family Directors, Inc., 200 The Riverway, Boston, MA 02215.

This report from Work/Family Directors, a consulting firm that manages a national network of child care resource and referral services for corporate clients, deals, as its title suggests, with the care of children who are mildly ill or recuperating from an illness. Issues are addressed from the perspective of the public health official, the child care provider, the child, the parent, the pediatrician, and the employer. That sick child care is a "gut-wrenching" issue is acknowledged, as is the need for shared responsibility among all these groups for solving the problems involved.

Six case studies illustrate models of sick child care at the child's regular center, care in a family day care center, in-home care, and care in a free standing infirmary. These models reflect awareness that needs will be different for each child and that the emotional needs of mildly sick children will be less simple to meet than their health needs. Most of the models appear to meet the needs of sick children to be in a familiar place, and some provide a familiar caregiver connected with the regular day care program.

The publication lists 20 basic criteria for sick child care models and a dozen recommendations for responding to unmet needs. Appendices list sick child care programs, state day care licensing agencies and bibliographic references.

The Child Care Catalog—Randy Lee Comfort and Constance D. Williams (Libraries Unlimited, Inc., ATTN: Department 58, P.O. Box 263, Littleton, CO 80160-0263, 1985) $23.50.

Designed for parents, teacher librarians, day-care centers and providers, and social service professionals among others, this catalog is organized into eight topical chapters. Each topic is preceded by introductory information. The catalog identifies child care information available through brochures, pamphlets, journals, organizations and agencies, film, audiovisual materials, annotated bibliographies, foundations and associations, model programs, and resource and referral centers. Individual chapters address options in child care; referral centers; choosing child care; operating a child care facility, including training programs; special needs children in child care; the role of state and federal government; legal aspects of child care; and additional sources of information.

Successful Strategies for Recruiting Family Day Care Providers—Tom Copeland and Megan Roach (Toys 'N Things Press, a division of Resources for Child Caring, Inc., 906 North Dale Street, St. Paul, Minnesota 55103, 1986) $17.95.

Much of the information in this handbook is based upon the experience of a one-year effort to recruit family day care providers conducted by the non-profit agency Resources for Child Caring, Inc. The campaign produced 346 new licensed day care providers, a 33% increase over the previous year. The report identifies and describes five components of a successful recruitment project: 1) defining, estimating and documenting the unmet child care need; 2) building long-term support for recruitment within regulatory departments and child care provider organizations; 3) professional promotional materials; 4) incentive programs to help providers overcome barriers to regulation (examples of incentives include free loans of equipment, discounted training classes, emotional support, and cash); and 5) a publicity effort geared toward the entire community.

It should be noted that the 1984-85 St. Paul project was begun in response to an alarming increase in calls to the county resource and referral service; the need for infant care alone outnumbered the available slots by 4 to 1. As a result of the campaign, the number of regulated child care slots for infants in Ramsey County increased for the first time in three years.

The materials used in the recruitment campaign are reproduced in the appendix to the handbook, including "Love for a Living" billboards, posters and brochures.

Children, Families and Child Care in Maryland—Maryland Committee for Children (Maryland Committee for Children, Inc., 608 Water Street, Baltimore, Maryland 21202, 1987) $7.95.

This second edition of a 1984 publication offers quantitative measures of the status of families and children in Maryland, with comparable national statistics. The information on child care comes from a data base maintained by the child care resource and referral counseling service sponsored by the Maryland Committee for Children and funded by state and local public agencies and foundations. The report documents that few family day care or group programs in Maryland accept or mainstream children with special needs or handicaps. Two-income families in the state spend about 10% of their income on child care, while single-parent families may spend up to 30% of their income for similar care. Average salaries in Maryland child care programs in 1986 were $7,614 for a teacher, $5,403 for an aide, and $8,049 for a family day care provider.

Call for Papers

The Association for the Care of Children's Health (ACCH) invites proposals for papers, workshops and posters to be presented at its 23rd annual conference, which will be held June 12-15, 1988 in Cleveland, Ohio. The conference will place particular emphasis on coordination of care, fostering teamwork among professionals and families, and advocacy for children and families. **Submissions must be received by August 1, 1987.** For more information contact ACCH, 3615 Wisconsin Avenue, N.W., Washington, D.C. 20016-3007, tel: (202) 244-1801.

NAACOG, the organization for obstetric, gynecologic and neonatal nurses, seeks abstracts for paper and poster presentations to be made at its research conference scheduled for July 29-30, 1988 in Toronto, Canada.
Abstracts must be postmarked no later than November 28, 1987. For guidelines and priorities, write or call Charlotte Green, Department of Education and Research, 600 Maryland Avenue, S.W., Suite 200E, Washington, D.C. 20024-2589, tel: 1-800-533-8822.

For Your Information

The **Division of Personnel Preparation, Office of Special Education and Rehabilitative Services, U.S. Department of Education** has provided new 1987-1990 funding for nine projects training personnel to work with handicapped or high-risk infants. Curricula, admission requirements and availability of financial assistance vary from institution to institution. The projects and contact people are:

University of Maryland
Department of Special Education
1208 Benjamin Building
College Park, MD 20784
Paula Beckman

University of Connecticut Health Science Center
Farmington, CT 06032
Mary Beth Bruder

University of Kentucky
Lexington, KY 40506
Judith Page

University of Southern Mississippi
Hattiesburg, MS 39406
Jane Siders

Wheelock College
Graduate School
200 The Riverway
Boston, MA 02215
Margot Kaplan-Sanoff/Suzanne McBride

University of North Carolina
Chapel Hill
Frank Porter Graham Child Development Center
54 By-Pass West
Chapel Hill, NC 27514
Don Bailey/Anita Farel

Gallaudet University
Department of Education
800 Florida Avenue, N.E.
Washington, D.C. 20002
Tom Jones/Barbara Bodner-Johnson

Northern Illinois University
Dekalb, IL 60115
Carol Czudnowski

Louisiana State University Medical Center
New Orleans, LA 70112
Suzanne Poulton

The Alliance for Better Child Care (ABC) is a new coalition of more than sixty women's, civic, trade union, business, educational, religious, service and advocacy organizations that have joined together to develop and support a significant national child care initiative. A child care bill is currently being drafted under ABC auspices and is expected to be introduced before Congress adjourns.

The new child care initiative will reflect a set of principles shared by ABC members, including:

- Improving access to quality child care for all families;
- Aiding low- and moderate-income parents in paying for such care;
- Providing for sliding fee scales to help facilitate the socioeconomic mix of children within child care facilities;
- Strenghtening child care standards and improving their implementation;
- Strengthening family day care as well as that provided in child care centers;
- Supporting parental involvement in child care;
- Supporting the development of training programs to ensure qualified staff in child care programs;
- Encouraging coordination among the various state and local agencies that affect young children and their families; and
- Providing sufficient funds to serve more children, ensure quality child care, and improve the level of compensation for child care workers.

ABC, based in Washington, D.C., will encourage the formation of state-level alliances (including members of one or more national organizations as well as unaffiliated state and local organizations) to broaden support for the effort. For more information, contact Amy Wilkins, Children's Defense Fund, 122 C Street, N.W., Washington, D.C. 20001, tel: (202) 628-8787.

Conference Call

July, 1987

July 16-18: Contemporary Forums will sponsor its conference entitled "Developmental Interventions in Neonatal Care," in San Francisco, California. The theme will be "Identifying Specialized Approaches with High Risk Infants: A Multidisciplinary Challenge." Conference faculty will include: Heidelise Als, Barbara Bennett, Forest C. Bennett, Edward J. Paquette, Peter A. Gorski, Karen A. Thomas, Gretchen Lawhon, Kathleen A. VandenBerg, and Raeone S. Zelle, among others. For information write or call Contemporary Forums, 530 La Gonda Way, Suite E, Danville, CA 94526, or call (415) 820-2800.

July 19-21: *Family Resource Coalition,* in cooperation with *Family Focus, Inc., Nova University Family Center* and *Support Group Training Project,* will host its First Summer Training Institute in Chicago, Illinois. Topic areas to be covered include primary prevention, social support networks, cultural variables and the new role of the professional. Faculty includes Blanca Almonte, Deborah Lee, Roni Leiderman, Wendy S. Masi, Phyllis Smith Nickel, Lynn E. Pooley and Judith Rosenberg. For information write or call Family Resource Coalition, 230 N. Michigan, #1625, Chicago, Illinois 60601, tel: (312) 726-4750.

August, 1987

Aug. 14-16: *The International Childbirth Education Association* will hold an International Convention in Washington, D.C. Featured speakers include Wendy Savage, Susan McKay, Libby Rosen, Robert Howard, Sarah Danner and Linda Todd among others. For information write or call ICEA DC Convention, PO Box 20048, Minneapolis, MN 55420-0048, tel: (612) 854-8660.

September, 1987

September 9-12: *The National Association of Social Workers, Inc.* will host "Social Work, '87," featuring four simultaneous specialty conferences. Sessions will include Working with Children 0-5: Early Intervention to Prevent Emotional Disorders and Adolescent Pregnancy and Prevention: A Role for Child Welfare. For information write or call NASW, 1987 Annual Conference, 7981 Eastern Avenue, Silver Spring, MD 20910, tel: (301) 565-0333.

September 10-12: *The University of Wisconsin* will sponsor a conference in Madison, Wisconsin on "Child Advocacy as a New Role for Professionals." Parental, individual and class advocacy issues will be addressed in areas including special education needs, child abuse and neglect and divorce. Write to Ann Bailey, Continuing Education Coordinator, University of Wisconsin, 610 Walnut Street, Room 456, Madison, Wisconsin 53705.

September 11-12: *The National Mental Health Association* will sponsor its Fourth Annual Scientific Symposium in Chicago, Illinois. The meeting is designed to inform the public and practitioners of new discoveries concerning mental illness, its prevention and treatment, and to promote increased funding for mental health research through action and advocacy. For information call Carol Schwartz, NMHA Field Services Department, tel: (703) 684-7722.

October, 1987

October 18-21: *Parent Care, Inc.* will host its Fourth International Parent Care Conference in Philadelphia, Pennsylvania. Presenters include Peggy Anderson, Alan R. Fleischman, Helen Harrison, Herb Koffler, Peter Gorski, Marie C. McCormick, Craig Ramey, Karen A. Shannon, Vince Hutchins, John H. Kennell, Woodie Kessell and Sumner Yaffe. For information contact George Peckham, M.D. Chief, Division of Neonatology, Room #2083, The Children's Hospital of Philadelphia, 34th St. & Civic Center Blvd., Philadelphia, PA 19104.

October 9-11: *UCLA Center for Preventive Psychiatry* in collaboration with the *Department of Pediatrics* will co-sponsor the first annual UCLA National Conference on Preventive Psychiatry, in Santa Monica, California. The theme will be "The Prevention of Mental Health Disturbances in Childhood." Speakers will include Michael B. Rothenberg, Nancy Brill, Leila Beckwith, Dennis D. Drotar, Christoph M. Heinicke, Dennis Cantwell, Richard D. Krugman and Judith Howard. For information contact the Department of Continuing Education in Health Sciences, UCLA Extension, P.O. Box 24901, Los Angeles, CA 90024, tel: (213) 825-6701.

October 25-28: *The American Association for Protecting Children* and the *Texas Coalition for the Prevention of Child Abuse* will co-sponsor their 111th annual meeting and conference, entitled "Protecting Children: Renewing Our Commitment," in Austin, Texas. Plenary and concurrent sessions will address the definition of child abuse and neglect, connections between prevention and intervention, mental health services and child protection, and emotional abuse of children, among other topics. Write Kathern Bond, American Association for Protecting Children, Inc., 9725 East Hampden Avenue, Denver, CO 80231-4919.

November, 1987

November 1-3: *The Division for Early Childhood (DEC) of the Council for Exceptional Children* will hold its third annual national conference on Young Children with Special Needs and Their Families in Denver, Colorado. Contact Early Childhood Conference, c/o Early Childhood Research Institute, 3811 O'Hara Street, Pittsburgh, Pennsylvania 15213, tel: (412) 431-3371.

Zero to Three: A Topical Index for Volume VII

This index groups by topic the articles and reviews of publications that have appeared in *Zero to Three* from September, 1986 through June, 1987. When an item is listed as "review of" this means that a brief summary of the publication appears in the issue of *Zero to Three* indicated.

Copies of the index for Volumes I through VI are available on request from the National Center. Back issues of *Zero to Three* are available for $4 each from the National Center for Clinical Infant Programs, 733 15th Street, N.W., Suite 912, Washington, D.C. 20005. Payment must accompany orders. NCCIP reserve the right to supply photocopies of issues no longer in print.

Note: An incorrect volume number appeared on the September, 1986 issue of *Zero to Three*. That issue should have been labelled Volume VII, Number 1, and articles from that issue will be so designated in this index.

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